

<b>Case Number:</b>	CM14-0158800		
<b>Date Assigned:</b>	10/02/2014	<b>Date of Injury:</b>	05/31/2002
<b>Decision Date:</b>	11/06/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Spine Surgery and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 46-year-old male who reported an injury on 05/31/2002. The mechanism of injury was not stated. The current diagnoses include status post anterior/posterior lumbar fusion at L4-S1 and history of intractable lumbar pain with radiculopathy. The latest Physician's Progress Report submitted for this review is documented on 08/14/2014. Previous conservative treatment is noted to include multiple medications and physical therapy. The injured worker presented on an electrical scooter. Physical examination was not provided on that date. Treatment recommendations at that time included continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Cellupedic king size bed (split king TZ200 Pampero), QTY:1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back - Lumbar and Thoracic (Acute and Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Mattress Selection

**Decision rationale:** The Official Disability Guidelines do not recommend using firmness as the sole criteria for mattress selection. There is no recent physical examination provided for this review. There is no documentation of spinal instability or a significant functional limitation. It is unclear how the requested durable medical equipment will specifically address the injured worker's current condition or improve function. As the medical necessity has not been established, the request cannot be determined as medically appropriate.

**King size S cape platform twin XL (Leggett & Platt), QTY: 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back - Lumbar and Thoracic (Acute and Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Mattress Selection

**Decision rationale:** The Official Disability Guidelines do not recommend using firmness as the sole criteria for mattress selection. There is no recent physical examination provided for this review. There is no documentation of spinal instability or a significant functional limitation. It is unclear how the requested durable medical equipment will specifically address the injured worker's current condition or improve function. As the medical necessity has not been established, the request cannot be determined as medically appropriate.

**Bilateral arm platforms for front wheeled walker:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back - Lumbar and Thoracic (Acute and Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Walking aid

**Decision rationale:** The Official Disability Guidelines recommend walking aids for specific indications. Framed or wheeled walkers are preferable for patients with bilateral disease. There is no recent physical examination provided for this review. There is no indication as to how the requested durable medical equipment will alter the current treatment plan or improve function. As the medical necessity has not been established, the request is not medically appropriate at this time.