

<b>Case Number:</b>	CM14-0052639		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	05/09/2006
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	04/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 patient is a 58-year-old male who has submitted a claim for lumbar post-laminectomy syndrome, bilateral lower extremity radiculopathy, left greater than right, and status post L4-5 and L5-S1 laminectomy discectomy associated with an industrial injury date of 05/09/2006. Medical records from 08/23/2013 to 06/17/2014 were reviewed and showed that patient complained of low back pain graded 4/10. Physical examination revealed tenderness upon palpation over the lumbar spine. Numerous trigger points through the lumbar paraspinal muscles were noted. Decreased lumbar ROM was observed. DTRs were 2+ throughout bilateral lower extremities. MMT was 4/5 for bilateral knee extension, ankle flexion and extension, and great toe extension otherwise normal. Sensation to light touch was decreased at S1 distribution (side not specified). SLR test was positive in the modified sitting position at 60 degrees (side not specified). EMG/NCV study dated 10/06/2009 revealed left and moderate right L5 radiculopathy and moderate bilateral S1 radiculopathy. MRI of the lumbar spine dated 09/02/2009 revealed L2-3, L3-4, L4-5, and L5-S1 severe facet hypertrophy, L4-5 disc protrusion with moderate lateral recess stenosis, and L5-S1 severe spondylosis, slight retrolisthesis, and disc protrusion. CT myelogram dated 11/02/2007 revealed L4-5 and L5-S1 foraminal stenosis and L4-5 and L5-S1 disc bulge and mild to moderate facet hypertrophy. Treatment to date has included L4-5 laminectomy discectomy, spinal cord stimulator implant (12/02/2010), intrathecal infusion pump, physiotherapy, aquatic therapy, orthopedic bed, and pain medications. Utilization review dated 04/10/2014 denied the request for orthopaedic mattress and electric hospital bed because there were no indications for the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Orthopedic Mattress:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Back Chapter, Mattress Selection.

**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, Mattress Selection.

**Decision rationale:** CA MTUS does not specifically address mattress selection. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Official Disability Guidelines (ODG) was used instead. ODG states that in mattress selection, it is not recommended to use firmness as a sole criterion. There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference and individual factors. In this case, the patient complained of chronic low back pain. However, the guidelines do not support the use of mattress for treatment of low back pain as it is extremely subjective. There is no discussion as to why variance from the guidelines is necessary. Therefore, the request for orthopedic mattress is not medically necessary.

**Electric Hospital Bed:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare National Coverage Determinations Manual.

**Decision rationale:** The CA MTUS and ODG do not specifically address the topic on hospital bed. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Medicare National Coverage Determinations Manual was used instead. It states that the criteria for a hospital bed include documentation that the patient's condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, and avoid respiratory infections) in ways not feasible in an ordinary bed or that the patient's condition requires special attachments that cannot be fixed and used on an ordinary bed. In this case, the patient's condition does not meet the criteria for hospital bed use. There was no documentation of required special attachments that cannot be fixed on an ordinary bed. It is unclear as to why variance from the guidelines is needed. Therefore, the request for an electric hospital bed is not medically necessary.