MAXIMUS Federal Services

| Case Number: | CM15-0107019 | | |
|---|---|---|---|
| Date Assigned: | 06/11/2015 | Date of Injury: | 06/07/2012 |
| Decision Date: | 07/13/2015 | UR Denial Date: | 05/12/2015 |
| Priority: | Standard | Application Received: | 06/03/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Arizona, California
Certification(s)/Specialty: Family Practice

## 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 62 year old female who sustained an industrial injury on 06/07/2012. Current diagnoses include lumbar sprain/strain, thoracic or lumbosacral neuritis or radiculitis, displacement of thoracic or lumbar intervertebral disc without myelopathy, and lumbosacral spondylosis without myelopathy. Previous treatments included medications, physical therapy, EMS unit, and home exercise program. Report dated 04/24/2015 noted that the injured worker presented with complaints that included low back pain with radicular pain in the right lower extremity. Pain level was 6-7 out of 10 on a visual analog scale (VAS). Physical examination was positive for lumbar spine tenderness and spasm, positive straight leg raise, decreased sensation, increased pain with extension, and decreased range of motion. The treatment plan included obtaining AME report, reviewed MRI of the lumbar spine from 2012, request for consultation, request for MRI of the lumbar spine, continue home exercise program, continue home EMS, and request for orthopedic celestial bed mattress to decrease pain, spasms, and medications, and increase activities of daily living. Disputed treatments include orthopedic bed celestial bed mattress.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Orthopedic bed; Celestial bed 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 (ODG), Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - Low back pain and pg 64.

**Decision rationale:** According to the guidelines, mattress selection is not recommended to use firmness as sole criteria. In a recent RCT, a waterbed (Aqua) and a body contour foam mattress (Tempur) generally influenced back symptoms, function, and sleep more positively than a hard mattress, but the differences were small. There is no evidence that the celestial bed mattress will provide long-term benefit for the claimant's back pain or spasms. The claimant had already received other interventions that would provide greater benefit. The request for the mattress above is not medically necessary.