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| Case Number: | CM15-0109031 | | |
| Date Assigned: | 06/15/2015 | Date of Injury: | 08/03/2013 |
| Decision Date: | 07/14/2015 | UR Denial Date: | 05/26/2015 |
| Priority: | Standard | Application Received: | 06/05/2015 |

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 34 year old male, who sustained an industrial injury on August 3, 2013 while working as a motorcycle officer. The mechanism of injury was a motorcycle accident. The diagnoses have included a closed head injury, post-traumatic headaches, bilateral shoulder strains, right elbow strain with ulnar neuritis, right wrist and hand contusion, lumbago, cervicgia, thoracic spine pain, facet syndrome, left facial contusion and dental pain. Treatment to date has included medications, radiological studies, medial branch blocks, radiofrequency ablation, transforaminal epidural steroid injections, physical therapy and a transcutaneous electrical nerve stimulation unit. Current documentation dated May 18, 2015 notes that the injured worker reported neck, arm, mid and low back pain. Examination revealed tenderness of the neck, upper back, lower back and posterior thighs. Range of motion of the neck was noted to be decreased. A Tinel's sign was positive in the left medial elbow. The treating physician's plan of care included a request for a retrospective bed and mattress (date of service 5/18/15) and a retrospective heating pad (date of service 5/18/2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective bed and mattress Qty: 1 with a dos of 5/18/2015: 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 Chapter.

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, there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. In this case, the claimant's need for a mattress or replacement was no medically justified. The mattress also does not fall other DME requirements and is not medically necessary.

Retrospective heating pad Qty: 1 with a dos of 5/18/2015: 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), Cold and Heat packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: According to the guidelines, heat is optional in the acute and subacute phases of low back pain. In this case, the injury was remote and the pain was chronic. The request for the heating pad was to be used as a muscle relaxer. There is lack of evidence to support its use for this purpose in the chronic phase. The request for the heating pad is not medically necessary.