MAXIMUS Federal Services

Case Number:	CM14-0181961		
Date Assigned:	11/06/2014	Date of Injury:	03/04/2010
Decision Date:	12/09/2014	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/03/2014

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 Surgery and is licensed to practice in New York. 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 has chronic back pain. The patient also has right hip pain. MRI the right hip shows a labral tear. The patient also has right knee pain which affects her walking and gait. She continues to have back pain. The patient had left knee surgery with partial meniscectomy in 2012. She had shoulder surgery for subacromial decompression in 2012. She had left shoulder surgery in 2011 with rotator cuff repair. On physical examination the patient has tenderness to palpation of the right hip and right trapezius. The right knee is stable but swollen. The patient has tenderness and spasms to the paraspinal musculature. Motor exam is normal in the bilateral lower extremities. There is decreased range of motion lumbar spine. At issue is whether additional treatment modalities are medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Therapeutic Pressure Gel 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS chronic pain treatment guidelines

Decision rationale: This patient does not meet established criteria for special mattress. The patient has chronic low back pain. The medical literature does not support specialized mattress is for the treatment of chronic low back pain. Review of published peer review literature does not recommend specialized mattress is for the treatment chronic low back pain. The requested Therapeutic pressure gel mattress is not medically necessary.

1 Prescription for Valium 10mg Quantity: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS chronic pain treatment guidelines, MTUS low back pain chapter

Decision rationale: MTUS chronic pain treatment guidelines do not recommend allowing for the treatment of chronic pain. This patient has chronic back pain and chronic muscle spasms. The medical records indicate that the patient has had multiple medications to date for the treatment of her chronic pain. The requested Valium is not medically necessary.