

Case Number:	CM14-0156631		
Date Assigned:	09/26/2014	Date of Injury:	02/14/2008
Decision Date:	02/25/2015	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/24/2014

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. 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

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

Patient is a 41 year-old male with date of injury 02/14/2008. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/09/2014, lists subjective complaints as pain in the low back. MRI of the lumbar spine (date not provided) was notable for a L2-L3 disc protrusion with multilevel spondylosis and disc bulges. Also a wedge compression fracture was present at T12. Conservative treatments to date include medications, inpatient rehabilitation, occupational and physical therapy and injections. Objective findings: Examination of the lumbar spine revealed restricted range of motion in all directions secondary to pain. Straight leg raising test was positive on the right and left side at 90 degrees in sitting position. Motor exam was 4/5 for the bilateral lower extremities. Light touch sensation was decreased over the medial and lateral calf on the right. Diagnosis: 1. Thoracic or lumbosacral neuritis or radiculitis 2. Intracranial hemorrhage 3. Chronic pain syndrome.

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 TWC 2014 Mattress Selection

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The Official Disability Guidelines state that 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. The request for an Orthopedic Mattress is not medically necessary.