

# Applied Assessments LLC

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Nov/21/2013

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Conductive garment for the Lumbar Spine and Mattress overlay

### A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

PM&R

Pain Medicine

### REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 09/13/13, 10/28/13

Patient re-evaluation dated 10/25/13, 09/10/13, 08/27/13

Initial consultation dated 01/03/12

IME dated 06/28/13

History and physical examination dated 02/23/12

Lumbar MRI dated 11/09/11

Office note dated 12/11/12

Undated request for reconsideration

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient felt a pop in his low back. MRI of the lumbar spine dated 11/09/11 revealed at L3-4 a 3 or 4 mm right lateralizing disc protrusion causing moderate right foraminal encroachment with flattening of the exiting right L3 roots. There is borderline or mild right lateral recess encroachment at the level of the proximal right L4 root. At L4-5 a 2 or 3 mm concentric disc bulge or protrusion is present with right foraminal annular fissuring. There is mild lateralization to the right foraminal region with mild right foraminal encroachment but no displacement of the exiting right L4 root. Per initial consultation dated 01/03/12, the patient has completed approximately 4 weeks of physical therapy. IME dated 06/28/13 indicates that he recently had 6 additional chiropractic visits approved. The patient underwent right transforaminal epidural steroid injection on 03/09/12

and prior to that he had some facet injections. The patient was determined to have reached maximum medical improvement as of 04/23/13 with 10% whole person impairment. Patient re-evaluation dated 09/10/13 indicates that low back pain is somewhat reduced. The patient complains of firmness of his mattress and is asking about the mattress overlay that was previously recommended. The patient is utilizing a portable TENS unit on a frequent basis. Patient re-evaluation dated 10/25/13 indicates that he continues to have difficulty lying on his firm mattress. On physical examination deep tendon reflexes are diminished in the bilateral lower extremities at 1/+2. There is diminished sensation L3, L4, L5 dermatomal regions on the right. Straight leg raising in the supine position is positive at 45 degrees on the right, negative on the left.

Initial request for mattress overlay was non-certified on 09/13/13 noting that the patient is currently dealing with stomach cancer and he is getting chemotherapy; this is not related to the original work injury. Mattress overlay is not supported by the evidence based guidelines, ODG. The denial was upheld on appeal dated 10/28/13 noting that it is evident that the patient has a comorbidity which is responsible for his bed sores that states he can document with photos and not the work injury of xx/xx/xx. The request does not comply with the Texas WC law and ODG.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The patient sustained injuries in xx/xxxx and treatment to date has included physical therapy, medication management, chiropractic treatment and injection therapy. The patient complains that he has difficulty lying on a firm mattress. However, the Official Disability Guidelines note 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 noted to be subjective and depends on personal preference and individual factors. The patient has been determined to have reached maximum medical improvement as of 04/23/13. There is no documentation of failure of conservative treatment including physical therapy and NSAIDs. As such, it is the opinion of the reviewer that the request is not recommended as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**