

Notice of Independent Review Decision

DATE OF REVIEW: 12/15/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 purchase of a P6 Flextop King Mattress, Flexfit 3 Adjustable Base, Mattress Pad, and Sheet Set with Shipping, Delivery, and Set-up between 10/08/2014 and 12/08/2014

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

The TMF physician reviewer is board certified in family practice with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the 1 purchase of a P6 Flextop King Mattress, Flexfit 3 Adjustable Base, Mattress Pad, and Sheet Set with Shipping, Delivery, and Set-up between 10/08/2014 and 12/08/2014 are not medically necessary to treat this patient's condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he fell. This resulted in injury to the thoracic and lumbar spine as well as his knee. The orthopedic evaluation from 11/01/04 stated that the patient was having intermittent cervical, left

knee and thoracolumbar pain. At that time, the treating physician ordered a posturepedic mattress. There is a current order for the patient to purchase a P6 Flextop King Mattress, Flexfit 3 Adjustable Base, Mattress Pad, and Sheet Set with Shipping, Delivery, and Set-up between 10/08/2014 and 12/08/2014 that has been denied by the insurance carrier.

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

Radiological evaluation and procedure reports note the stability of the compression fracture as well as the presence of bulges and mild stenosis of the spinal cord at T12 and L1. The notes indicated that the patient is at full work duty and sleeps well. While the patient previously had a posturepedic bed through worker's compensation, he does not meet the ODG criteria for durable medical equipment that states:

1. Can withstand repeated use, i.e., could normally be rented, and used by successive patients;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of illness or injury;

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL

- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)