

Case Number:	CM13-0025220		
Date Assigned:	12/11/2013	Date of Injury:	01/07/2002
Decision Date:	02/04/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	09/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 physician 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.

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 is a 52-year-old female who reported an injury on 01/07/2002. The mechanism of injury was not provided, nor was their details on the initial course of treatment. The patient has had ongoing complaints of left wrist pain and burning in the lumbar region. The patient states that local ice, stretching, and rest helps to relieve the pain. The patient also reports radiating pain to her left gluteal region and left thigh, with some radiation to the left leg. She is known to have received good relief with a lumbar medial branch block and nerve radiofrequency rhizotomy in 12/2012, and would like a repeat of this treatment. The patient's current medications include Ambien CR 6.25 mg 1 tab by mouth at bedtime as needed for insomnia; Soma 350 mg, 1 tab by mouth every 12 hours; clonidine 0.1 mg 1 tab every 12 hours; Duragesic 100 mcg, 1 patch to skin every 2 days; Flector patch 180 mg, 1 patch to skin twice daily as needed for superficial inflammatory pain; gabapentin 600 mg, 1 per 8 hours by mouth for nerve pain control; hydrocodone 10 mg/650 mg of APAP, 1 tablet by mouth every 6 hours as needed for breakthrough pain; ibuprofen 800 mg, 1 tab by mouth every 8 hours; omeprazole 20 mg, 1 tab by mouth daily as needed for heartburn; and Topamax 50 mg, ½ to 1 tab by mouth 1 to 2 times a day for nerve pain. The patient's current diagnoses include lumbosacral neuritis, lumbar sprain, lumbar arthritis, sacral radiculitis, and degeneration of lumbar intervertebral disc.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ring cushion: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
http://arthritis.about.com/od/backpain/tp/coccyx_cushion.htm

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Durable Medical Equipment

Decision rationale: The California MTUS and ACOEM Guidelines did not specifically address the use of durable medical equipment; therefore, the Official Disability Guidelines were supplemented. ODG defines durable medical equipment as an equipment that can withstand repeated use i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. A ring cushion is generally used to increase comfort while sitting. It can be utilized by both injured and non-injured individuals. As such, this does not meet the ODG requirements of serving a medical purpose and not being useful to a person in the absence of illness or injury. As such, the request for ring cushion is non-certified.

Carisoprodol (Soma) 350mg tablet, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: The California MTUS Guidelines do not recommend the use of Soma. The most current clinical note available for review is dated 09/23/2013; although it has the patient's current pain level, there was no assessment of the effect of the Soma since the last assessment. As such, the medical necessity of the request cannot be determined. Therefore, the request for Carisoprodol (Soma) 350 mg tablet, #30, is non-certified.