

Case Number:	CM13-0047466		
Date Assigned:	06/09/2014	Date of Injury:	10/17/2003
Decision Date:	08/04/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/03/2013

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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker is a female with date of injury 10/17/2003. Per primary treating physician's progress report dated 9/12/2013, the injured worker continues to complain of back pain which she indicates is severe. She indicates she is under the care of her primary care physician and is being treated for gastritis and elevated liver enzymes. She discussed the Norco with her physician who indicated it is okay to continue on this medication. She is requesting a new lumbosacral orthosis as the Velcro on hers is no longer functional. On examination she ambulates with the aid of a cane. There is tenderness in the lower lumbar paravertebral musculature. Forward flexion is to 40 degrees, extension to 10 degrees, lateral bending to 30 degrees. Diagnoses include 1) lumbar spondylosis 2) chronic pain syndrome 3) status post bilateral knee arthroscopies 4) psychological diagnosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) LIGHTWEIGHT LUMBOSACRAL ORTHOSIS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Per the MTUS Guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The injured worker complains of continued back pain described as severe, but the clinical documents do not report an acute injury that may benefit from short term use of a lumbar support for symptom relief. This request is for a replacement lumbosacral orthosis as the injured worker reports her current one has Velcro that is no longer functional. The request for one (1) lightweight lumbosacral orthosis is determined to not be medically necessary.

TENS SUPPLIES TO INCLUDE: BATTERIES, ELECTRODES, AND CONDUCTIVE GEL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy section Page(s): 114-116.

Decision rationale: The use of TENS for chronic pain is not recommended by the MTUS Guidelines as a primary treatment modality, but a on-month home-based TENS trial may be considered if used as an adjunct to a program of evidence-based functional restoration in certain conditions. The injured worker does not meet the medical conditions that are listed by the guidelines where a TENS unit may be beneficial. The TENS unit is also being used as a primary treatment modality, which is not supported by the guidelines. There are criteria for the use of TENS specified by the guidelines, of which there is not adequate documentation to support. The criteria also include evidence that other appropriate pain modalities have been tried (including medication) and failed, of which this is not evident in the clinical documentation. The criteria also specify that there is to be a treatment plan including specific short and long term goals of treatment with the TENS unit. The use of a TENS unit in the management of the injured worker's pain is not medically necessary, so the supplies to support the use of TENS are also not medically necessary. It is also noted that there have been two requests for a TENS unit previously that had been denied. The request for TENS supplies to include: batteries, electrodes, and conductive gel are determined to not be medically necessary.

SOMA 350MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) section, Weaning of Medications section Page(s): 29, 124.

Decision rationale: The MTUS Guidelines do not recommend the use of Soma, and specifically state that the medication is not indicated for long-term use. There are precautions with sudden discontinuation of this medication due to withdrawal symptoms in chronic users. This medication should be tapered, or side effects of withdrawal should be managed by other means. The request for Soma 350 mg #30 is determined to not be medically necessary.

