MAXIMUS Federal Services

Case Number:	CM14-0113868		
Date Assigned:	08/01/2014	Date of Injury:	09/04/2002
Decision Date:	10/20/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/21/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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:

The injured worker is a 62 year old male who had a work related injury on 09/04/02 while sweeping up plaster on top of a roof and fell about 15-20 feet to the ground. Shortly after the fall he developed pain in his right groin. He was initially seen on 09/10/02. Diagnosed with a hernia on 10/08/02. In October of 2002, he was diagnosed with a hernia, cervical sprain/strain, and lumbar sprain/strain. In 2004, he was diagnosed with a disc protrusion at L4-5 and a disc protrusion at C5-6. The injured worker has received physical therapy as well as medication. The most recent medical record submitted for review is dated 09/09/14. He complained of cervical spine pain being 8/10, complained of bilateral upper extremity pain with numbness and tingling. Lumbosacral pain was rated 5/10 and he complained of right lower extremity pain and numbness and tingling. He is scheduled for trigger point injections to the cervical and lumbar spine and he reports that Norco and Soma are helpful for his symptoms. In review of the medical records there is no documentation of VAS scores with and without medication. No documentation of functional improvement. Diagnosis is cervical sprain/strain and bilateral radiculopathy secondary to degenerative disc disease and a disc protrusion. Lumbosacral sprain/strain. Right lower extremity radicular symptoms secondary to disc protrusion and degenerative changes. Prior utilization review dated 07/09/14 modified the prescription for Norco to initiate weaning, and non-certified the solar care heating system and the lumbosacral orthosis. The current request is for solar care FIR heating system with FIR pad, Norco 10/325mg #60, and Lumbosacral orthosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solar Care FIR Heating System with FIR Pad: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Infrared therapy (IR)

Decision rationale: The request for Solar Care FIR Heating System with FIR Pad is not medically necessary. ODG, not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). Based on the current evidence based guidelines, medical necessity has not been established.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. There are no documented VAS pain scores for this patient with or without medications. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of this medication has not been established.

Lumbar Sacral Othosis (LSO): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter Lumbar supports

Decision rationale: The request for LSO is not medically necessary. The clinical documentation submitted as well as current evidence based guidelines do not support the request. Guidelines state that lumbar supports have not been shown to have any long lasting benefit beyond the acute phase. Therefore, medical necessity has not been established.