

<b>Case Number:</b>	CM14-0115049		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	06/10/2008
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery

### 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 56-year-old male who sustained an industrial injury on June 10, 2008. He has reported injury to the neck, low back, right foot, left elbow, right shoulder, and right knee and has been diagnosed with spondylosis, degenerative disc disease at multiple level, disc space narrowing at L1-2, L2-3, more L1-2, facet hypertrophy lower lumbar spine. Treatment has included chiropractic therapy, lumbar epidural steroid injections, massage therapy, and medications. Currently the injured worker complains of low back pain, left hip pain, and left leg pain. Exam note 6/9/14 demonstrates complaints of low back pain with left hip pain. Numbness and tingling is noted. Weakness is noted in the tibialis anterior at 3/5 on the right and 4/5 on the left. The treatment plan included physical therapy and medications. On June 24, 2014 Utilization Review modified Norco 10/325 mg # 60, durable medical equipment pre fabricated lumbar brace and non certified Soma 350 mg # 100 and Durable Medical Equipment (DME) Rental: Cryotherapy 3-5 Times Per Day for 3-9 Months citing the MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg #100:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES-TREATMENT FOR WORKERS' COMPENSATION PAIN PROCEDURE SUMMARY LASAT UPDATED 05/15/2014.

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

**Decision rationale:** Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 29, Carisoprodol (Soma), does not recommend Soma for long term use. It is a skeletal muscle relaxant, which has abuse potential due to its sedative and relaxant effects. In this case, the exam note from 6/9/14 does not demonstrate prior dosages and response to Soma. In addition, the guidelines do not recommend long term use. Therefore the determination is for non-certification.

**Norco 10/325mg #100:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 6/9/14. Therefore the determination is for non-certification.

**Durable Medical Equipment (DME) Purchase:Lumbar Cybertech Brace:** 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 TREATMENT WORKERS' COMPENSATION LOW BACK PROCEDURE SUMMARY.

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

**Decision rationale:** CA MTUS/ACOEM guidelines, Chapter 12, page 301 states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." Therefore the request does not meet recommended guidelines and determination is for non-certification.

**Durable Medical Equipment (DME) Rental: Cryotherapy 3-5 Times Per Day for 3-9 Months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES- TREATMENT WORKERS' COMPENSATION- LOW BACK PROCEDURE SUMMARY.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back, Cold/Heat packs.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG Low Back section, cold/heat packs is recommended as an option for acute pain. It is recommended for at home application of cold packs for the first few days of acute complaint. The ODG does not recommend a motorized hot cold therapy unit as cold packs is a low risk cost option. Therefore the determination is for non-certification.