

<b>Case Number:</b>	CM13-0011202		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	09/30/2012
<b>Decision Date:</b>	06/10/2014	<b>UR Denial Date:</b>	08/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2013

### 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:

The injured worker is a female with date of injury of 9/30/2012. Per the primary treating physician's progress report, the injured worker states that she stopped taking her medication. She states that the medication made her light headed. She still complains of an ache in the neck . On exam cervical spine, the range of motion flexion was 95 degrees, the extension was 35 degrees, the right rotation was 65 degrees, the left rotation was 65 degrees, the right lateral flexion was 40 degrees, the left lateral flexion was 40 degrees. The lumbar spine is tender, the range of motion flexion was 45 degrees, the extension was 15 degrees with pain, the straight leg raise was positive with low back pain. The bilateral shoulder is tender left worse than right, the range of motion had decreased flexion at 185 degrees, extension at 35 degrees, abduction at 160 degrees. The diagnoses include: 1) C-spine sprain/strain; 2) T-spine sprain/strain; 3) L-spine sprain/strain; 4) L4-L5 degenerative disc disease; and 5) bilateral shoulder sprain/strain, impingement, left worse than right.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE (1) ORTHO STIM FOUR (IV)/EMS UNIT BETWEEN 07/08/2013 AND 09/21/2013:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY SECTION, INTERFERENTIAL CURRENT STIMULATION (ICS) SECTION Page(s):.

**Decision rationale:** The OrthoStim IV unit has several modes of treatment, which would each need to be medically necessary for this particular unit to be determined to be medically necessary. The modes available include interferential current stimulation (ICS) and neuromuscular electrical stimulation (NMES). An interferential stimulator is not recommended as an isolated treatment; however, it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. The Chronic Pain Guidelines support the use of an interferential stimulator for a one (1) month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. The request is not for a one (1) month trial; however, and the unit is not recommended for use without the trial and document evidence of benefit. The NMES is not recommended by the guidelines for the treatment of chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. The request for one (1) OrthoStim IV/EMS unit is determined to not be medically necessary.

**ULTRAM 150 MG #30 BETWEEN 07/08/2013 AND 09/21/2013:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS FOR NEUROPATHIC PAIN SECTION AND OPIOIDS, SPECIFIC DRUG LIST SECTION Page(s): 82, 83, 93.

**Decision rationale:** Ultram is a centrally acting synthetic opioid analgesic and is not recommended as a first-line oral analgesic. The injured worker's pain is described in the medical reports as an ache in the neck, and she has been diagnosed with sprain/strains in her back including cervical spine, thoracic spine and lumbar spine. She also has bilateral shoulder pain with impingement signs. The injured worker's medications listed are Ultram ER and over the counter Aleve; however, it is noted that Final Determination Letter for IMR Case Number CM13-0011202 4 she has stopped taking her medications due to side effects of light headedness. There is no documentation provided for review that indicates that the use of Ultram has been effective at providing pain relief and increase in function, or an improvement in quality of life. The Chronic Pain Guidelines recommend discontinuing opioids if there is no overall improvement in function. A slow taper is recommended for opioids rather than sudden discontinuation, due to the probable risk of withdrawal symptoms. This request is for continuing treatment; however, and not for a weaning or tapering plan. The request for Ultram 150 mg #30 is determined to not be medically necessary.

