

Case Number:	CM13-0043717		
Date Assigned:	01/24/2014	Date of Injury:	06/28/2013
Decision Date:	04/22/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/31/2013

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 Physical Medicine & Rehabilitation 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:

This 71 year-old female patient sustained an injury from a slip and fall exiting a bathroom on 6/28/13 while employed by the [REDACTED]. Request under consideration include ORTHOSTIM4 EOC1, EOC2, PURCHASE AND SUPPLIES AS NEEDED. Diagnoses included Thoracic and Lumbar musculoligamentous sprain/ strain with left lower extremity; right wrist forearm tendinitis; and s/p left distal radius displaced fracture per x-rays. Her left wrist was placed in a cast and she was on TTD. Report of 6/28/13 noted patient for follow-up of left wrist injury from a slip and fall at work. Exam noted left wrist with severe tenderness, moderate swelling with decreased range; however with neuro/vascular intact. X-rays showed acceptable alignment of left distal radius fracture with improved position. Diagnoses was left wrist fracture with treatment for Lidocaine 1%; Buipivacaine local block; long arm cast. Report of 8/9/13 noted patient will continue conservative care, recommending chiropractic treatment after cast comes off. Exam showed tenderness of left lumbar to hip; normal range able to touch toes, twist and extend; normal sensation; normal gait; normal reflexes. Diagnoses included Closed radial fracture; back strain. Report of 9/4/13 from the provider noted The OrthoStim 4 is to help enhance pain relief. The request for Naproxen was certified; however, the request for OrthoSTim 4 and supplies were non-certified on 10/16/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

ORTHOSTIM4 EOC1, EOC2, PURCHASE AND SUPPLIES AS NEEDED: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-119, 121..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION. Page(s): 114-117..

Decision rationale: The Expert Reviewer's decision rationale: This 71 year-old female patient sustained an injury from a slip and fall exiting a bathroom on 6/28/13 while employed by the [REDACTED]. Request under consideration include ORTHOSTIM4 EOC1, EOC2, PURCHASE AND SUPPLIES AS NEEDED. Diagnoses included Thoracic and Lumbar musculoligamentous sprain/ strain with left lower extremity; right wrist forearm tendinitis; and s/p left distal radius displaced fracture per x-rays. Her left wrist was placed in a cast and she was on TTD. Report of 6/28/13 noted patient for follow-up of left wrist injury from a slip and fall at work. Exam noted left wrist with severe tenderness, moderate swelling with decreased range; however with neuro/vascular intact. X-rays showed acceptable alignment of left distal radius fracture with improved position. Diagnoses was left wrist fracture with treatment for Lidocaine 1%; Buipivacaine local block; long arm cast. Report of 8/9/13 noted patient will continue conservative care, recommending chiropractic treatment after cast comes off. Exam showed tenderness of left lumbar to hip; normal range able to touch toes, twist and extend; normal sensation; normal gait; normal reflexes. Diagnoses included Closed radial fracture; back strain. Report of 9/4/13 from the provider noted The OrthoStim 4 is to help enhance pain relief. The request for Naproxen was certified; however, the request for OrthoSTim 4 and supplies were non-certified on 10/16/13 citing guidelines criteria and lack of medical necessity. Per MTUS Chronic Pain Treatment Guidelines, interferential stimulation is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of transcutaneous stim unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received conservative treatment to include medications and exercise which is documented to control her symptoms and is taking Naproxen. There is no documentation on the short-term or long-term goals of treatment with the interferential unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the Home Orthostim unit purchase as there is no documented failed trial of TENS. There is no evidence for change in work status, increased in ADLs, decreased VAS score, or treatment utilization from any transcutaneous stimulation therapy already rendered. The ORTHOSTIM4 EOC1, EOC2, PURCHASE AND SUPPLIES AS NEEDED is not medically necessary and appropriate.