

<b>Case Number:</b>	CM13-0047616		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/04/2012
<b>Decision Date:</b>	02/24/2014	<b>UR Denial Date:</b>	10/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesia, has a subspecialty in Acupuncture and Pain Medicine and is licensed to practice in California. He 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 physician reviewer was selected based on his 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 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:

55 year old female injured worker with date of injury 4/4/12 with related right wrist pain with numbness and tingling sensation of the right thumb. She also reported ongoing weakness of right hand. She is diagnosed with cervical sprain/strain with bilateral upper extremity radiculitis; thoracolumbar sprain/strain; bilateral shoulder impingement syndrome; bilateral hip sprain; bilateral knee patellofemoral arthralgia; status post carpal tunnel release 7/11/13. Currently, her pain complaints primarily center on the surgical scar with possibility of retained sutures. She is refractory to physical therapy and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco hydrocod/apap 10/325 mg #30:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74, 81.

**Decision rationale:** Per MTUS CPMTG p81, with regard to opioids for chronic pain: "Recommended as the standard of care for treatment of moderate or severe nociceptive pain

(defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." As the injured worker's current pain complaints primarily center on the surgical scar with possibility of retained sutures, which represents a new manifestation or source of this worker's current pain complaints, the guidelines for the on-going use of opioids for chronic pain are not applicable. The pain sourcing from her surgical scar accurately fits the description of acute nociceptive pain, therefore the request is medically necessary.

**OrthoStim 4 (OS4) unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 117, 118, 121.

**Decision rationale:** The OrthoStim 4 unit delivers multiple types of electrical stimulation which are not recommended by the MTUS CPMTG. Neuromuscular electrical stimulation is not recommended. "NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain." Galvanic stimulation is not recommended. "Considered investigational for all indications." Interferential current stimulation is not recommended as an isolated intervention. "There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatments alone." The documentation submitted for review do not indicate additional treatment in the form of exercise or a return to work. The primary treating physician's supplemental report (undated) notes that the OrthoStim 4 is generally classified as durable medical equipment. "According to the ODG TWC (2013), Procedure Summary - Knee, on page 699, these modalities are generally recommended if there is a medical need and if the device meets Medicare's definition of durable medical equipment." However, the hierarchy of evidence places MTUS above ODG guidelines. Also, the ODG guidelines referenced by the treating physician are vaguely related to the medical treatment proposed, whereas the MTUS guidelines are specifically related to it. I respectfully disagree with the primary treating physician, the request is not medically necessary.