MAXIMUS Federal Services

Case Number:	CM13-0064997		
Date Assigned:	01/03/2014	Date of Injury:	04/25/2012
Decision Date:	07/10/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/12/2013

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 patient is a 52-year-old female who has filed a claim for right ankle sprain with compensatory left ankle sprain, cervical sprain, and lumbar sprain associated with an industrial injury date of April 26, 2012. Review of progress notes reports pain symptoms of the bilateral shoulders, wrists, knees, ankles, cervical spine, and lumbar spine. Findings include tenderness and hypertonicity of the cervical musculature, left more than right. There is increased left-sided neck pain radiating to the left shoulder and interscapular region with axial compression and Spurling's tests. Lumbar MRI performed in February 13, 2013 showed L4-5 and L5-S1 degenerative dehiscence with disc protrusions indenting the anterior lumbosacral sac, and severe right and mild left lateral recess stenosis at L4-5. MRI of the right shoulder showed mild impingement syndrome. Treatment to date has included opioids, muscle relaxants, Lamotrigine, exercises, acupuncture, cervical epidural steroid injection, and right wrist carpal tunnel injection.Utilization review from December 04, 2013 denied the requests for continue with HEP and therapy (Orthostim 4), additional cervical mechanical traction, re-supply of batteries for home Orthostim 4 unit, re-supply of pads for home Orthostim 4 unit, re-supply of wires for home Orthostim 4 unit, Norco, and Fexmid.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUE WITH HEP AND THERAPY (ORHOSTIM 4): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-118.

Decision rationale: The Orthostim 4 unit incorporates interferential, TENS, NMS/EMS, and galvanic therapies into one unit. The Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not generally recommended and is appropriate for cases where pain is ineffectively controlled with medications. TENS is recommended for chronic intractable pain (at least 3 months duration), evidence of failure of other appropriate pain modalities, and presence of a treatment plan including specific short- and long-term goals of treatment. Neuromuscular electrical stimulation is under study; galvanic stimulation (high-voltage, pulsed stimulation) is investigational for all indications. There is no documentation of a rationale identifying why a combined electrotherapy unit would be required. In addition, the patient already has an Orthostim unit. There is no indication for another unit. Therefore, the request for an Orthostim 4 is not medically necessary.

ADDITIONAL CERVICAL MECHANICAL TRACTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NEUROMUSCULAR ELECTRICAL STIMULATION Page(s): 121.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) NECK AND UPPER BACK CHAPTER, TRACTION.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. ODG recommends home cervical patient-controlled traction for patients with radicular symptoms, in conjunction with a home exercise program. ODG does not recommend powered traction devices. There is documentation that patient has authorization for chiropractic therapy, but patient has not attended any sessions. Although the patient presents with findings supporting cervical radiculopathy, there is no documentation regarding previous cervical mechanical traction or derived benefits to support additional cervical mechanical traction. Therefore, the request for additional cervical mechanical traction was not medically necessary per the guideline recommendations of ODG.

RE-SUPPLY OF BATTERIES FOR HOME ORTHO STIM 4 UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the Orthostim 4 unit is not medically, none of the associated services are medically necessary.

RE-SUPPLY OF PADS FOR HOME ORTHOSTIM 4 UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the Orthostim 4 unit is not medically, none of the associated services are medically necessary.

RE-SUPPLY OF WIRES FOR HOME ORTHOSTIM 4 UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the Orthostim 4 unit is not medically, none of the associated services are medically necessary.

NORCO (UNSPECIFIED DOSAGE AND QUANITY): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The patient has been on this medication since October 2012. There is no documentation regarding objective functional benefits derived from this medication, or of periodic urine drug screens to monitor proper medication use. The requested quantity and dosage are not specified. Therefore, the request for Norco is not medically necessary.

FEXMID (UNSPECIFIED DOSAGE AND QUANITY): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. It may be effective in reducing pain and muscle tension, and increasing mobility. However, it showed no benefit beyond NSAIDs in pain and overall improvement. The patient has been on this medication since October 2012. This medication is not recommended for long-term use. In addition, the requested quantity and dosage are not specified. Therefore, the request for Fexmid is not medically necessary.