

Case Number:	CM14-0026516		
Date Assigned:	06/20/2014	Date of Injury:	05/15/2007
Decision Date:	07/18/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	03/03/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 38-year-old female who reported an injury on 05/15/2007. The mechanism of injury was not provided within the medical records. The clinical note dated 01/30/2014 is largely illegible. The diagnoses indicated right shoulder impingement, right elbow epicondylitis/cubital tunnel syndrome, and right wrist tendinitis. The injured worker reported right shoulder pain. On physical exam of the right shoulder there was tenderness to the AC with resistance on flexion and abduction; flexion was 95, abduction was 80, extension 25, adduction 30, and internal and external rotation were 60. The injured worker had muscle spasms and headaches. The injured worker's prior treatments included diagnostic imaging, physical therapy, and medication management. The injured worker's medication regimen included Norco and Anaprox DS. The provider submitted request for 1 supply for EMS unit, Norco, and Anaprox DS. A request for authorization dated 01/30/2014 was submitted for medication and supplies for EMS unit; however, rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 - SUPPLIES FOR EMS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES devices).

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

Decision rationale: The California MTUS Guidelines do not recommended the use of EMS units for chronic pain. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. The guidelines do not recommend the use of EMS units for chronic pain and NMES is used primarily as part of a rehab program following strokes. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for a stroke. In addition, the documentation submitted indicates the injured worker has findings that would support she has chronic problems with her shoulder, elbow, and wrist. There is lack of documentation of functional improvement from the use of the electrical muscle stimulation. Therefore, the request for 1 supply for EMS unit is not medically necessary.

NORCO 10/325MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug use behaviors, and side effects. Furthermore, the request did not indicate a frequency for the medication. Therefore, the request for Norco is not medically necessary.

ANAPROX DS 550MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 73.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines state Anaprox DS is indicated for Osteoarthritis or ankylosing spondylitis. Anaprox is indicated for osteoarthritis or ankylosing spondylitis. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for osteoarthritis or ankylosing spondylitis. In addition, there was lack of documentation of efficacy or functional improvement of the Anaprox DS. Furthermore, the request did not indicate a frequency for the medication. Therefore, the request for Anaprox DS 550 mg #60 is not medically necessary.