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| Case Number: | CM14-0204925 | | |
| Date Assigned: | 12/17/2014 | Date of Injury: | 06/26/2012 |
| Decision Date: | 02/11/2015 | UR Denial Date: | 11/03/2014 |
| Priority: | Standard | Application Received: | 12/08/2014 |

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 Rehab 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 36 year old female with date of injury 06/01/12. The treating physician report dated 11/13/14 (11) indicates that the patient presents with pain affecting the neck, bilateral shoulders, left elbow, bilateral wrists, and bilateral hands. The patient complains of significant pain and spasm to the neck with radiating pain and numbness down to her left wrist and first three fingers of her left hand. The physical examination findings reveal there is spasm about the bilateral trapezial areas, increased to the left. There is paraspinal tenderness upon palpation, increased to the left. Further examination of the cervical spine reveals a limited range of motion accompanied by pain. Examination of the bilateral shoulder reveals compartments are soft. There is mild effusion noted in the left shoulder as well as increased pain with motion. Inspection of the left wrist reveals there is mild tenderness over the dorsal aspect with mild swelling and a limited range of motion. Prior treatment history includes massage therapy, physical therapy, cortisone injection to the left shoulder, subacromial decompression of the left shoulder, dorsal ganglion cyst removal of the left wrist, trigger release of the left thumb and index finger, and prescribed medications. Current medications include Anaprox, Flexeril, Lexapro, and Ultram. The current diagnoses are: 1. Cervical spine, disc bulge 2. Cervical spine, left-sided C5 and C6 radiculopathy 3. Left shoulder, rotator cuff tendonitis 4. Left shoulder, impingement syndrome 5. Status post left shoulder, subacromial decompression 6. Status post left wrist, dorsal ganglion cyst removal by 7. Status post trigger release, left thumb and index finger. The utilization review report dated 11/3/14 denied the request for Orthostim x1 purchase based on a lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthostim x1 purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 114-11.

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

Decision rationale: The injured worker presents with pain affecting the neck, bilateral shoulders, left elbow, bilateral wrists, and bilateral hands. The current request is for Orthostim x1 purchase. The treating physician report dated 11/13/14 does not explain the medical necessity of the current request. A letter of appeal by the treating physician dated 10/28/14 (216) states, "the goal of this office is to direct care towards the functional restoration of our patients, which is the primary rationale for this Orthostim 4 prescription." The physician goes on to state that Orthostim 4 is also an effective non-pharmaceutical treatment option and believes that the injured worker will benefit from using this device. An Orthostim is a combo unit that has NMES and Interferential current stimulation. The MTUS Guidelines do not recommend interferential current stimulation (ICS). MTUS goes on to say that if ICS is decided to be used the criteria should be based on after effectiveness is proven by a physician or licensed provider of physical medicine when chronic pain is ineffectively controlled with medications, history of substance abuse or from significant post-operative conditions. There is no documentation provided that states the injured worker's symptoms are ineffectively controlled with medications and there is no evidence of substance abuse. The injured worker is six weeks post left shoulder open subacromial decompression and notes an improvement in pain, range of motion, and strength. In this case, the injured worker's symptoms are improving and there is no evidence provided that indicates the injured worker has any history of substance abuse or aberrant behavior with the use of current medications. Furthermore, MTUS does not recommend interferential current stimulation. The request is not medically necessary.