

Case Number:	CM15-0141172		
Date Assigned:	07/30/2015	Date of Injury:	04/29/2011
Decision Date:	08/28/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 69 year old female who sustained a work related injury April 29, 2011. Past history included status post cervical fusion C4-C7 September 2012 and revision June 2014. According to a primary treating physician's progress report, dated June 16, 2015, the injured worker presented with worsening cervical pain. Most of the handwritten notes are difficult to decipher. Objective findings included; cervical tenderness to palpation bilaterally with spasm, left greater than right. There is right shoulder pain with tenderness to palpation and positive impingement sign. Diagnoses are status post cervical fusion with revision; right shoulder rotator cuff syndrome (726.1); unspecified disorder of joint shoulder region (719.91) right sprain-strains unspecified site knee and leg (844.9); chondromalacia patella (717.7); bilateral elbow, possible cubital tunnel. Treatment plan included a surgical consultation for arthroscopic surgery-decompression and other handwritten notes are difficult to decipher. At issue, is a request for authorization for supplies for an OrthoStim unit and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Supplies for OrthoStim 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): 114-121.

Decision rationale: Regarding the request for ortho stim unit, this unit is a combination electrical stimulation unit which includes TENS, interferential current, galvanic stimulation, and neuromuscular stimulation. In order for a combination device to be supported, there needs to be guideline support for all incorporated modalities. Chronic Pain Medical Treatment Guidelines state that TENS is not recommended as a primary treatment modality, but a one month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines go on to state the galvanic stimulation is not recommended. Additionally, guidelines state that interferential current stimulation is not recommended as an isolated invention except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Finally, guidelines state that neuromuscular electrical stimulation is not recommended. Within the documentation available for review, there is no indication that the patient is failed a TENS unit trial, as recommended by guidelines prior to an interferential unit trial. Additionally, there is no indication that the interferential current stimulation will be used as an adjunct to program of evidence-based rehabilitation, as recommended by guidelines. Furthermore, guidelines do not support the use of galvanic stimulation or neuromuscular stimulation. As such, the currently requested OrthoStim is not medically necessary.

Norco 7.5/325mg Q8H PRN #900: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-80.

Decision rationale: Regarding the request for Norco (hydorcodone/acetaminophen), Chronic Pain Medical Treatment Guidelines state that Norco is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function in terms of specific examples of functional improvement, and no discussion regarding side effects. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydorcodone/acetaminophen) is not medically necessary.

