

Case Number:	CM15-0160950		
Date Assigned:	08/27/2015	Date of Injury:	12/13/2003
Decision Date:	09/30/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/17/2015

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

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 65 year old female, who sustained an industrial injury on 12-13-2003. She reported continuous trauma injuries to multiple regions including headaches, neck pain, bilateral shoulder pain, upper, mid and low back. Diagnoses include fibromyalgia, cervical spondylosis, radiculopathy, and myofascial pain, bilateral cubital syndrome, bilateral carpal tunnel syndrome; SLAP tear right shoulder, bilateral impingement syndrome, bilateral knee pain, depression and anxiety. Treatments to date include aquatic therapy, physical therapy, chiropractic therapy, and steroid and Hyalgan injections to bilateral knees. Currently, she complained of pain in multiple areas including bilateral knees, low back, and constant headaches. On 6-17-15, the physical examination documented cervical tenderness with decreased sensation and restricted range of motion. There was resisted painful range of motion of bilateral shoulders with positive impingement signs. There was bilateral wrist tenderness with positive Tinel's test. There was low back pain with decreased sensation noted. The plan of care included requests to authorize Vicodin 5-300 #30 and unknown supplies for interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown supplies for interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: Based on the 7/15/15 progress report provided by the treating physician, this patient presents with increased bilateral knee pain, headaches, sharp neck pain radiating to bilateral shoulders with associated burning sensation, clicking of shoulders with circular motions, back pain radiating down left buttock/leg/foot, and numbness on reaching out with the arms. The treater has asked for UNKNOWN SUPPLIES FOR INTERFERENTIAL UNIT but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is unable to lay flat in bed, and unable to sleep due to pain per 7/15/15 report. The patient needs to have extensive dental work due to grinding of teeth per dental AME per 7/15/15 report. The patient has 50% restricted range of motion which is very painful per 7/15/15 report. MRI of left knee from 8/13/09 shows 2.2x1.8cm distal femoral enchondroma, with chondromalacia changes of patellofemoral joint and no evidence of ligamentous injury or meniscal tear per 7/15/15 report. The patient's work status is partially disabled. MTUS, Interferential Current Stimulation section, pg. 118-120: While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Treater has not discussed reason for the request, nor how the device will be used, or what body part will be treated. Medical records show the requested treatment is not intended as an isolated intervention, as the patient is being prescribed Vicodin, Motrin, and Protonix per 7/15/14 report. With regards to interferential unit, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse or pain due to postoperative conditions or unresponsiveness to conservative measures. Per utilization review letter dated 8/10/15, the patient's pain is relieved by NSAIDs which shows patient is still responsive to conservative measures. As the patient's use of the IF unit is not indicated, the request for supplies for IF unit is also not in accordance with guideline recommendations. Therefore, the request for IF unit supplies IS NOT medically necessary.

1 prescription for Vicodin 5/300mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, long-term assessment, Criteria for Use of Opioids, Long-term Users of Opioids (6-months or more); Opioids, specific drug list, Hydrocodone/Acetaminophen; Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: Based on the 7/15/15 progress report provided by the treating physician, this patient presents with increased bilateral knee pain, headaches, sharp neck pain radiating to bilateral shoulders with associated burning sensation, clicking of shoulders with circular motions, back pain radiating down left buttock/leg/foot, and numbness on reaching out with the arms. The treater has asked for 1 PRESCRIPTION FOR VICODIN 5/300MG #30but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is unable to lay flat in bed, and unable to sleep due to pain per 7/15/15 report. The patient needs to have extensive dental work due to grinding of teeth per dental AME per 7/15/15 report. The patient has 50% restricted range of motion which is very painful per 7/15/15 report. MRI of left knee from 8/13/09 shows 2.2x1.8cm distal femoral enchondroma, with chondromalacia changes of patellofemoral joint and no evidence of ligamentous injury or meniscal tear per 7/15/15 report. The patient's work status is partially disabled. MTUS Guidelines Criteria For Use of Opioids Section under Long-Term Users of Opioids, Pages 88-89: Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS Criteria For Use of Opioids Section under Therapeutic Trial of Opioids, Page 78: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. MTUS Criteria for Use of Opioids Section under Therapeutic Trial of Opioids, Page 77: Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures. The treater does not discuss this request in the reports provided. It is not clear when Vicodin was initiated by treating physician, but as of 5/16/15 AME report, the patient is taking Ibuprofen, Protonix, Vicodin previously and Norco currently. MTUS requires appropriate discussion of all the 4A's; however, in addressing the 4A's, the treater does not discuss how this medication significantly improves patient's activities of daily living. No pain scales are included, and no validated instrument is used to show analgesia. There is no UDS, no CURES and no opioid contract provided. Given the lack of documentation as required by MTUS, the request does not meet the specifications given by the guidelines. Therefore, the request IS NOT medically necessary.