

<b>Case Number:</b>	CM15-0075439		
<b>Date Assigned:</b>	04/27/2015	<b>Date of Injury:</b>	04/28/2010
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2015

### 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 64 year old female, who sustained an industrial injury on 04/28/2010. The initial complaints or symptoms included neck pain, back pain, bilateral shoulder pain and right knee pain. The initial diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, x-rays, MRIs, conservative therapies, right knee surgery and lumbar injections. Several documents within the submitted medical records are difficult to decipher. However, it is reported that the injured worker complains of continued pain in the low back with radiation to both lower extremities, and continued epigastric pain with no overall improvement. The injured worker's current or recent medication regimen was not noted. The diagnoses include right shoulder strain, sprain, thoracic spin strain/sprain, gastritis and duodenitis, other specified gastritis, and non-organic sleep disorder. The request for authorization consisted of replacement interferential unit for home use, and medications (Anaprox, Imitrex and Norco). A progress report dated January 20, 2015 indicates that the patient interferential unit needs to be replaced since her old unit stopped functioning and cannot be repaired. The note indicates that she uses it daily for pain control allowing for activities of daily living.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325 mg Qty 60 (1 every 12 hrs as needed): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this 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 or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. 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 (hydrocodone/acetaminophen) is not medically necessary.

**Home use, Interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 54.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 118-120 of 127.

**Decision rationale:** Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with specific objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.