

Case Number:	CM13-0034827		
Date Assigned:	12/11/2013	Date of Injury:	05/01/2009
Decision Date:	02/07/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/15/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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 57-year-old male who reported an injury on 05/01/2009. The mechanism of injury was not provided. There were very few legible notes submitted for review; however, it appears the patient has received treatment to his neck and low back. It is noted on the progress report dated 03/05/2013 that the patient had recently received a cervical epidural steroid injection; however, the injection date was not provided. The patient reported a 50% to 60% pain relief with the injection but duration of relief was not provided. Other treatments the patient has tried include ice, heat, NSAIDs, lumbar epidural steroid injections, narcotics, and physical therapy of unknown duration. The patient has had an MRI to an unknown body region; results were not discussed in the medical records. The patient is noted to have significant depression, anxiety, and anger management issues as well as an adjustment disorder. The patient's current diagnoses include 3 level cervical discopathy, left wrist tendonitis/resolved; L5-S1 disc herniation, sleep disturbance, anxiety; depression, and an internal medicine disorder. The patient's psychological diagnoses include adjustment disorder with mixed anxiety and depression, insomnia due to physical limitations, male hypoactive sexual desire disorder due to physical limitations, and psychological factors affecting medical condition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transportation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Transportation

Decision rationale: The California MTUS/ACOEM Guidelines do not address the need for transportation; therefore, the Official Disability Guidelines were supplemented. Official Disability Guidelines state that for medically necessary transportation to and from appointments, patients must have disabilities preventing them from self transport. It is noted in the 06/18/2013 clinical note that the patient was advised not to drive while he was using narcotics, and that it may be beneficial if the patient was provided transportation to and from his appointments. This is the only indication provided in any of the medical records submitted for review as to why the patient needs transportation. Medication use is not considered a disability preventing an individual from self-transport, as the medication can be held until afterward. As such, the guideline recommendations are not met, and the request for transportation is non-certified.

A Pro-Stim unit 5.0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 113-118.

Decision rationale: Based on the physician's own description of a Pro-Stim 5.0 unit as requested for this patient, the unit contains galvanic stimulation, interferential stimulation, TENS therapy, as well as neuromuscular stimulation for treatment of chronic pain. The California MTUS/ACOEM Guidelines do not recommend galvanic stimulation, as it is considered investigational for all indications. Also, guidelines do not recommend interferential current stimulation, although it can be trialed in patients whose pain is ineffectively controlled due to diminished effectiveness of medications, ineffectively controlled due to medication side effects, history of substance abuse, in postoperative situations, or if the patient is unresponsive to conservative measures such as repositioning, heat, or ice. There is no discussion provided in the medical records submitted for review regarding the ineffectiveness of the patient's current pain medications. However, there are also no pain levels provided, nor are there pain medication assessments available. Furthermore, California MTUS/ACOEM Guidelines do not recommend neuromuscular electrical stimulation, as it is primarily used as part of a rehabilitation program following a stroke and there is no evidence to support its use in chronic pain. Although guidelines do recommend a trial of a TENS unit, the Pro-Stim multi therapy unit is a multi-faceted therapy, and is not appropriate at this time. As such, the request for a Pro-Stim unit 5.0 is non-certified.

