

Case Number:	CM13-0057327		
Date Assigned:	12/30/2013	Date of Injury:	04/16/2012
Decision Date:	04/29/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/25/2013

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 Emergency Medicine 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 presented with date of injury of 4/16/12 and mechanism of injury was not provided. The patient has a diagnosis of lumbar radiculopathy, cervical radiculopathy, lumbar spinal stenosis, medial plantar neuropathy, L5-S1 discopathy with R sided neuropathy and post L knee arthroscopy. Multiple medical records from primary treating physician and consultants reviewed and the patient reports complaints of low back pain radiating to L lower extremity. Pain is 2/10 without medication and 1/10 with medications and the patient received an epidural steroid injection on 10/29/13 providing significant (>80%) relief. Prior exam on 9/30/13 reports pain of 7/10. The objective exam reveals spinal vertebral tenderness at lumbar spine L4-S1, lumbar myofascial tenderness and there was normal sensory and motor function. Bilateral sciatic notch tenderness and bilateral positive straight leg raise were noted. Trigger Points Impedance Imaging (11/23/12) is consistent with Myofascial Pain Syndrome and no other advance imaging reports were provided. The patient is undergoing a home exercise program and has received trigger point neurostimulation, epidural steroid injections and unknown number of physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

A PRO-STIM 5.0 UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation Section Page(s): 114-120.

Decision rationale: As per treating physician's provided report, the Pro-Stim 5.0 is a multi-function electrical stimulator that has Galvanic Stimulation, Transcutaneous electrical nerve stimulation (TENS), Interferential current stimulation and neuromuscular electrical stimulation (NMES). There is also a "Russian stimulation" function that has no noted definition in the MTUS Chronic pain/ACOEM guidelines or ODG. There is no online information available about this unit despite multiple search attempts. All functions are based on the primary treating providers report. The unit is requested for patient's low back pain. Since this unit has multiple functions, the determination will be made if the preponderance of functions are not recommended as per MTUS guidelines. Patient failed to meet any criteria for any of the unit's functions. Since all functions are not recommended with 2 functions (Galvanic Stimulation and NMES) not recommended under any chronic pain situation, the entire unit is not recommended. Pro-Stim 5.0 unit is not medically necessary.