MAXIMUS Federal Services

Case Number:	CM15-0221172		
Date Assigned:	11/16/2015	Date of Injury:	08/06/2014
Decision Date:	12/29/2015	UR Denial Date:	10/16/2015
Priority:	Standard	Application Received:	11/10/2015

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 70 year old female, who sustained an industrial injury on 8-06-2014. The injured worker was diagnosed as having cervical disc degeneration, lumbar herniated disc, spondylolisthesis, and bilateral shoulder impingement. Treatment to date has included diagnostics. On 9-08-2015 (per the Doctor's First Report of Occupational Injury or Illness), the injured worker's subjective complaints were not noted. A physical exam was not noted. Current medication regimen, if any, was not noted. She was not interested in any surgery. The treatment plan included house exercise, compound cream, and Pro Stim 5.0. Work status was modified-sedentary work. Previous and recent PR2 reports (8-26-2015 and 6-03-2015) noted complaints of pain in the neck, upper and lower back, bilateral shoulders-arms, right hip-thigh, left hip, and left ankle. Physical exam on 8-26-2015 noted only that light touch sensation was intact to the left lower extremity. On 10-16-2015 Utilization Review non-certified a request for Pro Stim 5.0.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pro Stim 5.0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents on 08/26/15 with pain in the neck, upper back, lower back, bilateral upper extremities, bilateral thighs, and left ankle. The patient's date of injury is 08/06/14. The request is for PRO STIM 5.0. The RFA is dated 09/08/15. Physical examination dated 08/26/15 is unremarkable. The patient's current medication regimen is not provided. Patient is currently working. MTUS Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy section, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "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. A jacket should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." In regard to the pro-stim unit for this patient's continuing pain, evidence of a successful 30 day trial has not been provided. It is not clear if this is a request for a rental or a purchase of the unit, as the RFA associated with the request does not specify if this is to be a trial rental or purchase. There is no evidence that this patient has trialed a pro-stim or IF unit to date. Were the request for a 30 day rental or trial the recommendation would be for approval. However, the purchase of such a unit without first demonstrating efficacy with a 30 day trial does not meet MTUS guideline procedures and cannot be substantiated. Therefore, the request IS NOT medically necessary.