

Case Number:	CM13-0051449		
Date Assigned:	12/27/2013	Date of Injury:	02/11/1993
Decision Date:	04/25/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/04/2013

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 New York and Tennessee. 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 is a 48-year-old male who was injured on February 11, 1993. The patient continued to experience severe pain in the lower back and thoracic area. The physical examination was notable for normal motor strength in all extremities, normal sensation in all extremities, and negative straight leg raises. Diagnoses included postlaminectomy syndrome of the thoracic spine, thoracic disc displacement, arachnoiditis, and lumbar spondylosis with myelopathy. The patient had undergone spinal fusion of the thoracic spine from T6-T10. The patient did not receive relief from opioid medications and was concerned about his spinal cord stimulation. The request for authorization for diagnostic and therapeutic electron procedure was submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

DIAGNOSTIC AND THERAPEUTIC ELECTRON PROCEDURE FOR THE THORACIC SPINE: 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)

Decision rationale: The procedure requested is Diagnostic and Therapeutic Electron procedure. The procedure in question applies electromagnetic pattern to identify the nerve that is causing the pain. A correcting electromagnetic signature is applied to the identified nerve to correct its abnormal signature and reduce pain. The California MTUS does not address this topic. ODG refers to Electromagnetic Pulsed Therapy. It is not recommended due to the lack of sufficient literature evidence. Studies supporting pulsed electromagnetic field stimulation therapy for occupational back pain are not of high quality. Scientific evidence recommending the procedure is not present. The lack of evidence does not allow determination of efficacy or safety.