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| Case Number: | CM14-0027519 | | |
| Date Assigned: | 04/30/2014 | Date of Injury: | 12/11/2012 |
| Decision Date: | 07/08/2014 | UR Denial Date: | 02/18/2014 |
| Priority: | Standard | Application Received: | 03/04/2014 |

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 Physical Medicine & Rehabilitation 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 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 injured worker is a 37-year-old female with a reported injury date on 12/11/2012; the mechanism of injury was not provided. The clinical notes dated 01/21/2014 noted that the injured worker had complaints that included intermittent pain and weakness to the cervical spine, lumbar spine, left shoulder, left elbow, left wrist, and right ankle. Additional complaints included left sided chest and rib pain and loss of sleep due to pain. Objective findings included +3 tenderness to palpation to the cervical paravertebral muscles with spasms, lumbar paravertebral muscles with spasms, anterior/lateral elbow, lateral /posterior shoulder and anterior/dorsal ankle. Additional findings included positive cervical compression test, positive Kemp's bilaterally, positive supraspinatus press test, positive Cozen's on the left elbow, positive Phalen's on the left wrist, and positive inversion test of the right ankle. The request for authorization for trigger point impedance (TPII) and localized intense neurostimulation therapy was submitted on 01/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRIGGER POINT IMPEDANCE (TPII): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <https://www.dovepress.com/Imaging-Guided-Hyperstimulation-Analgesia-In-Low-Back-Pain-Peer-Reviewed-Article-Jpr-Recommendation1> Imaging-Guided Hyperstimulation Analgesia In Low Back Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Gorenberg, M., & Schwartz, K. Imaging-Guided Hyperstimulation Analgesia in Low Back Pain. Journal of Pain Research, 2013, 487-491. Retrieved From <http://www.ncbi.nlm.nih.gov/pmc/art>.

Decision rationale: The request for trigger point impedance imaging is not medically necessary. It was noted that the injured worker had complaints that included intermittent pain and weakness to the cervical spine, lumbar spine, left shoulder, left elbow, left wrist, and right ankle. Additional complaints included left sided chest and rib pain and loss of sleep due to pain. Objective findings included +3 tenderness to palpation to the cervical paravertebral muscles with spasms, lumbar paravertebral muscles with spasms, anterior/lateral elbow, lateral /posterior shoulder and anterior/dorsal ankle. Additional findings included positive cervical compression test, positive Kemp's bilaterally, positive supraspinatus press test, positive Cozen's on the left elbow, positive Phalen's on the left wrist, and positive inversion test of the right ankle. The article referenced states that the technique shows promising results. However, it requires future investigation and randomized, controlled, longitudinal studies. As this technique is not currently recommend by peer-reviewed literature and is considered still in the testing phase; the request is not medically necessary.

LOCALIZED INTENSE NEUROSTIMULATION THERAPY; ONCE (1) A WEEK FOR SIX-TWELVE (6-12) WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NEUROMUSCULAR ELECTRICAL STIMULATION Page(s): 121.

Decision rationale: The request for localized intense neurostimulation therapy, once (1) a week fir six-twelve (6-12) weeks is not medically necessary. It was noted that the injured worker had complaints that included intermittent pain and weakness to the cervical spine, lumbar spine, left shoulder, left elbow, left wrist, and right ankle. Additional complaints included left sided chest and rib pain and loss of sleep due to pain. Objective findings included +3 tenderness to palpation to the cervical paravertebral muscles with spasms, lumbar paravertebral muscles with spasms, anterior/lateral elbow, lateral /posterior shoulder and anterior/dorsal ankle. Additional findings included positive cervical compression test, positive Kemp's bilaterally, positive supraspinatus press test, positive Cozen's on the left elbow, positive Phalen's on the left wrist, and positive inversion test of the right ankle. The California MTUS guidelines state that neuromuscular electrical stimulation (NMES) is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. As this technique is not currently recommended by the guidelines and it did not appear it would be used as part of a habilitation program following stroke, this request is not medically necessary.

