

Case Number:	CM14-0031695		
Date Assigned:	06/20/2014	Date of Injury:	06/16/2010
Decision Date:	07/18/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/13/2014

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 Orthopedic Surgery, 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 injured worker is a 50-year-old who was reportedly injured on June 16, 2010. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated May 13, 2014, indicated that there were ongoing complaints of low back and right knee pains. Current pain was stated to be 7/10-8/10 without medications and 3/10 with medications. The physical examination demonstrated a slightly antalgic gait, decreased lumbar spine range of motion and positive facet loading on the right side. The paravertebral musculature was mildly tender. There were diagnoses of long-term medication use and lumbosacral spondylosis. A lumbar spine magnetic resonance image was requested as well as 12 sessions of aquatic therapy. Previous treatment included a lumbar radiofrequency nerve ablation, which produced partial relief of low back pain. A request had been made for transcranial magnetic therapy and was not certified in the pre-authorization process on March 5, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcranial magnetic stimulation therapy, twice to three times weekly for twenty to thirty sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines mental illness and stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) MENTAL ILLNESS & STRESS, TRANSCRANIAL MAGNETIC THERAPY, UPDATED JUNE 12, 2104.

Decision rationale: According to the Official Disability Guidelines, the use of transcranial magnetic stimulation is under study for Post-Traumatic Stress Disorder (PTSD). There is no indication of any mention of using it for treatment for other medical conditions. There is no mention in the attachment record that the injured employee has PTSD, nor is it clear what the intention is to use this treatment for. The request for transcranial magnetic stimulation therapy, twice to three times weekly for twenty to thirty sessions, is not medically necessary or appropriate.