

Case Number:	CM14-0092192		
Date Assigned:	07/25/2014	Date of Injury:	10/13/2011
Decision Date:	10/24/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/18/2014

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, has a subspecialty in Interventional Spine 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 is a 61 year old female with date of injury 10/13/11. The treating physician report dated 4/14/14 indicates that the patient presents with pain affecting the neck rated a 5-6/10 with paresthesia of the left upper extremity, left shoulder pain rated 7/10, mid back pain is 6-7/10, right ankle pain status post ORIF surgery rated a 5-6/10, anxiety and abdominal pain. The physical examination findings reveal tenderness of the left shoulder, thoracic spine, PSIS, lateral malleolus, suboccipitals, scalenes and SCMs with positive cervical compression and decreased lumbar ranges of motion. The current diagnoses are: 1.Cervical HNP 2.Cervical DDD 3.Cervical radiculopathy 4.Left shoulder arthrosis 5.Lower back pain 6.Lumbar radiculopathy 7.S/P right ankle ORIF surgery. The utilization review report dated 5/29/14 denied the request for localized intensified neurostimulation therapy 1x6 lumbar and thoracic spine based on lack of guideline support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Localized Intensified Neurostimulation Therapy 1x week x 6weeks Lumbar Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PERCUTANEOUS ELECTRICAL NERVE STIMULATION Page(s): PAGE 97.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC guideline, Low back chapter online, for Hyperstimulation analgesia

Decision rationale: The patient presents with chronic cervical, thoracic, lumbar, left shoulder and right ankle pain. The current request is for localized intense neurostimulation therapy (LINT) 1 x a week for 6 weeks lumbar and thoracic spine. The treating physician report dated 4/14/14 states, "LINT T/S, L/S 1x6." The ODG lumbar chapter states for Hyperstimulation Analgesia, "Not recommended until there are higher quality studies." The current request for LINT is still considered investigational and is not supported by the ODG. As such, the request is not medically necessary and appropriate.