

<b>Case Number:</b>	CM15-0199342		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	04/09/2014
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2015

### 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, Hawaii  
 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 38 year old male, who sustained an industrial injury on 4-9-2014. Medical records indicate the worker is undergoing treatment for lumbar spine sprain-strain, lumbar disc displacement and lower limb radicular syndrome. A progress note dated 9-8-2014 reported the injured worker complained of low back pain that radiated to the bilateral lower extremities. A more recent progress report dated 8-20-2015, reported the injured worker complained of low back pain. Physical examination revealed no bruising, swelling, atrophy or lesion at the lumbar spine with tenderness to palpation of the bilateral sacroiliac joints and lumbosacral spinous processes. Lumbar range of motion was 20 degrees extension, 40 degrees flexion and 20 degrees right and left lateral bending. Treatment to date has included physical therapy, chiropractic care, acupuncture and medication management. The physician is requesting LINT therapy 1x week x6 weeks for the Lumbar spine. On 10-5-2015, the Utilization Review noncertified the request for LINT therapy 1x week x6 weeks for the Lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LINT therapy 1xwk x 6 wks for the Lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

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

**Decision rationale:** The patient presents with pain affecting the low back, and right shoulder with radiation to the neck. The current request is for LINT therapy 1x wk x6 wks for the Lumbar spine. The treating physician report dated 8/20/15 (7B) states, "Request authorization for LINT therapy once a week for 6 weeks to the Lumbar Spine." The requesting report provided no further rationale for the current request. The MTUS Guidelines do not address LINT. The ODG Guidelines 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 ODG. The current request is not medically necessary.