MAXIMUS Federal Services

Case Number:	CM15-0054031		
Date Assigned:	03/27/2015	Date of Injury:	07/11/2013
Decision Date:	05/06/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/23/2015

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 29 year old who sustained an industrial injury on 07/11/2013. Diagnoses include cervical spine pain, cervical spine disc displacement, cervical spine radiculopathy, bilateral shoulder impingement syndrome, left shoulder SLAP tear, bilateral shoulder impingement syndrome, thoracic spine pain, thoracic spine sprain/strain, low back pain, lumbar spine disc displacement, lumbar spine radiculopathy and sleep disorder. Treatment to date has included diagnostics, medications, chiropractic sessions, physical therapy, and shockwave therapy. A physician progress note dated 02/24/2015 documents the injured worker has radicular neck pain and muscle spasms. Pain is constant and rated as a 6-7 out of 10. He has burning bilateral shoulder pain, which he rates as 4-5 out of 10. He has radicular mid back pain and muscle spasms with pain rated 6-7 out of 10, and low back pain and muscle spasms with pain rated as 6-7 out of 10. Medications help with his pain and improve his ability to have a restful sleep. Range of motion of the cervical and lumbar spine is restricted. Bilateral shoulder range of motion is limited. Current treatment plan is for continuation of chiropractic treatments, physiotherapy, and shockwave therapy, referred to an orthopedic surgeon for a consultation regarding the bilateral shoulders, pain management consultation and medications. Treatment requested is for Localize Intense Neurostimulator Therapy (LINT) 1 time per week for 6 weeks, and Neuromuscular diagnostic procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Localize Intense Neurostimulation Therapy (LINT) 1 time per week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Hyperstimulation analgesia.

Decision rationale: The patient presents with lumbar spine radiculopathy. The current request is for Localize Intense Neurostimulation Therapy (LINT) one time per week for 6 weeks. The treating physician states, "The patient is to undergo a course of Localize Intense Neurostimulation Therapy, in a frequency of once per week, for a period of 6 weeks, for the thoracic spine, lumbar spine, for each separately and subsequently." (58B) The ODG guidelines state, "Not recommended until there are higher quality studies." In this case, the treating physician has requested a treatment that is not supported by the ODG guidelines. The current request is not medically necessary and the recommendation is for denial.

Neuromuscular diagnostic procedure: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Online Low Back chapter: EMGs (electromyography)).

Decision rationale: The patient presents with lumbar spine radiculopathy. The current request is for Neuromuscular Diagnostic Procedure. There is no specific discussion found in the medical records discussing a Neuromuscular Diagnostic Procedure. The treating physician's 06/16/14 states, "The patient requested an EMG/NCV study of the bilateral upper and lower extremities." (58B) The ODG guidelines state, "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." In this case, the treating physician has documented that the patient complains of radicular symptoms in the low back but the patient had an EMG done on 03/27/14 (258B) which was documented as abnormal with either right ulnar nerve pathology vs. a right sided cervical radiculopathy. The patient has not had any significant changes in symptoms since the previous EMG study. The current request is not medically necessary and the recommendation is for denial.