MAXIMUS Federal Services

Case Number:	CM14-0143643		
Date Assigned:	09/12/2014	Date of Injury:	07/24/2013
Decision Date:	01/05/2015	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/04/2014

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 and 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 56 year old female with an injury date on 07/24/2013. Based on the 06/24/2014 hand written partially template progress report provided by the treating physician, the diagnoses are:1. Cervical Spine -MLDB/NFN2. Thoracic -Spondy3. Lumbar- MLDP4. Bilateral shoulder-ALOA/tendinitis5. Bilateral elbow- R/O ID6. Bilateral wrist- R/O ID7. Bilateral Knee- R/O IDAccording to this report, the patient complains of "intermittent, mild body pain, no rad, no N/T today." Pain is increase with prolonged walking and bending. Exam findings show positive Kemp's test, bilateral. Mild tenderness is noted at the paraspinal muscles and upper trapezius. Pain is rated as a 2/10 at the cervical, thoracic, and lumbar spine; and a 1/10 at the bilateral shoulder, elbow, wrist and knee. There were no other significant findings noted on this report. The utilization review denied the request for Localized intense neurostimulation therapy LINT-thoracic (1 weekly for 12 weeks) on 11/10/2014 based on the ODG guidelines. The requesting physician provided treatment reports from 01/28/2014 to 07/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Localized intense neurostimulation therapy LINT-thoracic (1 weekly for 12 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: According to the 06/24/2014 report, this patient presents with intermittent, mild body pain, no rad, no N/T today." Per this report, the current request is for Localized intense neurostimulation therapy LINT-thoracic (1 weekly for 12 weeks). Regarding Hyperstimulation analgesia, ODG guidelines states "Not recommended until there are higher quality studies." In this case, the requested Neurostimulation Therapy is not supported by the guidelines, recommendation is for denial.