

<b>Case Number:</b>	CM13-0018937		
<b>Date Assigned:</b>	03/12/2014	<b>Date of Injury:</b>	03/10/2010
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	08/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/30/2013

### 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 Pain Medicine, 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 59 year old female who was injured on 03/10/2010 while unloading about 100 five gallon paint buckets from truck and injured low back. Prior treatment history has included (list prior treatments). The patient is status post right L4-5 laminotomy on 06/05/2012. Diagnostic studies reviewed include MR arthrogram of the left shoulder showing evidence of prior rotator cuff tendon repair with a combination of post surgical changes and moderate to high grade partial thickness tearing. The presence of contrast within the subacromial/subdeltoid bursa may be injection related or due to a non-water tight repair. Mild AC joint osteoarthritis. MRI scan of the lumbar spine dated 07/15/2013 reveals lumbar spondylosis L2-3 through L5-S1 disc. A 5 mm posterior osteophyte disc complex is seen, more prominent laterally, and on the left side with severe narrowing of left L4-5 neural foramen. At L5-S1, 4 mm posterior osteophyte disc complex. At L3-4, 3 mm posterior osteophyte disc complex. PR-2 dated 08/02/2013 documented the patient to have complaints of worsening daily and constant severe low back pain, primarily on the right at the L4-5 level extending down the bilateral legs, right greater than left, to the top of her foot with burning sensations. She has occasional right hip pain; asymptomatic at the current time. She has worsening constant left shoulder pain. Current medications include Lidoderm 5% patch and Ultram 50 mg tablet. Discussion: The patient was referred to a psychiatrist for treatment for depression, which she states has improved recently, as well as for clearance for a spinal cord stimulator trial. Authorization request was made for pain management consultation and spinal cord stimulator trial once cleared. Orthopedic progress note dated 08/20/2013 documented the patient continues to await authorization for the requested spinal cord stimulator trial. The patient had psychiatric clearance with [REDACTED] 10/31/2012. Her primary complaint is related to her lumbar spine and lower extremities. She has complaints of worsening numbness in the left lower extremity primarily in an L5 dermatome distribution.

She has ongoing constant left shoulder pain with painful limited range of motion. Current medications are Lidoderm 5% patch and Ultram 50 mg tablet. Objective findings on exam included examination of the shoulders showed no gross atrophy of the shoulder musculature. On palpation there is palpable tenderness over the anterolateral aspect of the left shoulder. Range of motion of the left shoulder is decreased. On examination of the lumbar spine the patient walks with a mild antalgic gait pattern. On palpation there is palpable tenderness over the right paravertebral muscles and upper buttocks. There is no evidence of tenderness over the sacroiliac joints. There is no tenderness over the sciatic notches and no tenderness over the flanks bilaterally. There is no tenderness over the coccyx. Sensory exam reveals decreased over right L5 and S1 dermatome distribution. Range of motion is decreased in flexion and extension. Reflexes in the knees are 2+ on the left and absent on the right. Reflexes in the ankles are absent. Motor power is 5/5 bilaterally. Straight leg raise is negative bilaterally at 90 degrees. Recommendations: 1. The patient's current psychiatric problems and symptoms constellation do not appear to require consideration of a psychopharmacologic regimen. 2. The patient is a candidate for opiate therapy. She would benefit from taking her medication on a time or pain contingent basis primarily and is a candidate for breakthrough or prn dosing.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PSYCHIATRIC CONSULTATION: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 96, 124.

**Decision rationale:** Per CA MTUS guidelines, psychiatry evaluation should be considered for patients requiring assistance w/ opiate weaning or pain unresponsive to escalating doses of opiates. Given this patient was only on a low/moderate level opiate regimen of Ultram 50 mg with no documentation of dose titration or trial of higher dose opiate regimens, Psychiatry evaluation is not medically necessary/indicated at this time.

#### **SPINAL CORD STIMULATOR TRIAL: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 107.

**Decision rationale:** Spinal Cord Stimulators are only indicated when less invasive methods including titration of pain medications, epidural steroid injections and/or radiofrequency nerve ablation procedures have been tried and failed. Since this patient does not meet any of these criteria, spinal cord stimulator trial is not medically necessary/indicated.

**PAIN MANAGEMENT CONSULTATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 31.

**Decision rationale:** Pain management consultation is indicated when a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. Since this patient does not meet any of these criteria, pain management consultation is not medically necessary/indicated.