

<b>Case Number:</b>	CM13-0025739		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	01/13/2011
<b>Decision Date:</b>	02/14/2014	<b>UR Denial Date:</b>	08/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational 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 physician 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic mid and low back pain reportedly associated with an industrial injury of January 13, 2011. Thus far, the applicant has been treated with the following: Analgesic medications; adjuvant medications; prior diagnosis with an old L1 vertebral body fracture; prior thoracolumbar fusion; unspecified amounts of physical therapy; attorney representation; and extensive periods of time off of work. In a Utilization Review Report of August 28, 2013, the claims administrator denied a request for an intrathecal pain pump, spinal cord stimulator, a thoracic laminectomy, exploration spinal fusion at T7 through T9, and associated hospitalization. The applicant's attorney later appealed. An emergency department note of October 31, 2013, does describe the applicant as paraplegic. The applicant is given a diagnosis of acute hip pain and discharged home. A handwritten note of September 18, 2013 is provided, difficult to follow, and notable for comments that the applicant is on Morphine for pain relief. He has apparently completed physical therapy. He is given a diagnosis of spinal cord injury. He is asked to continue Morphine for pain relief. A physiatrist note of October 28, 2013, is notable for comments that the applicant is status post a traumatic spinal cord injury. He is paraplegic. He is using intermittent self-catheterization to void periodically, it is stated. A later pain management note of October 16, 2013 is difficult to follow, not entirely legible, is notable for comments that the applicant has failed opioid therapy, failed Lyrica, and failed psychotropic medications. Morphine is continued. The applicant has also failed methadone. The treating provider states that the insurance company should recommend the proposed spinal cord stimulator with associated intrathecal pain pump.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Intrathecal Pain Pump:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52-53 of 127.

**Decision rationale:** No, proposed intrathecal pain pump is not medically necessary, medically appropriate, or indicated here. As noted on Page 52 of the MTUS Chronic Pain Medical Treatment Guidelines, implantable drug delivery systems are recommended only as an end-stage treatment alternative for selected individuals after failure of at least less invasive methods and following a successful temporary trial. While one of those indications does include severe, refractory spasticity in those individuals with spinal cord injuries who cannot tolerate oral baclofen, in this case, there is no evidence that oral baclofen has in fact been tried and failed. There is no evidence that a successful one-month trial of the intrathecal pain pump was obtained before permanent implantation of the device was sought. Most of the notes from the attending provider are sparse, handwritten, and not entirely legible. The notes of the providers which were included in the packet apparently did not include a note of the attending provider who is seeking the procedure in question. Therefore, the request is not certified.

**Spinal Cord Stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulator.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101 of 127.

**Decision rationale:** Similarly, the proposed spinal cord simulator is also not medically necessary, medically appropriate, or indicated here. As noted on page 101 of the MTUS Chronic Pain Medical Treatment Guidelines, precursor psychological evaluations are endorsed in those individuals prior to insertion of a spinal cord stimulator and/or prior to insertion of an intrathecal drug delivery system. In this case, it does not appear that the applicant has undergone the precursor spinal cord stimulator. While Page 107 of the MTUS Chronic Pain Medical Treatment Guidelines does suggest the spinal cord stimulators can be effective in the treatment of a failed back syndrome and spinal cord injury, both of which appear to be present here, in this case, the attending provider is concurrently seeking authorization for further spinal surgery. This appears to be somewhat incongruous. Again, no clear rationale for these procedures was attached to the request for authorization or applications for Independent Medical Review. Therefore, the request is not certified.

**Thoracic Laminectomy T7-9:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107 of 127.

**Decision rationale:** The proposed thoracic laminectomy at T7 through T9 is not medically necessary, medically appropriate, or indicated here. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8 Table 8-8, discectomy or fusion for non-radiating pain or in the absence of evidence of nerve root compromise is "not recommended." In this case, there is no clear radiographic evidence of residual neurologic or nerve root compromise following prior unspecified fusion surgery. No clear surgical target has been suggested here. Again, the notes provided do not include the notes of the attending provider seeking the surgery. Therefore, the request is not certified.

**Exploration Spinal Fusion:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** Similarly, the proposed exploration spinal fusions are also not certified. Again, the MTUS-adopted ACOEM Guidelines in Chapter 8 Table 8-8 do not recommend a discectomy or fusion in the absence of nerve root compromise. In this case, the documentation on file does not establish the presence of a residual nerve root compromise following prior unspecified spine surgery.

**Medical clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://emedicine.medscape.com/article/1127055-overview>. Preoperative Evaluation and Management . Author: Robert A Schwartz, MD, MPH; Chief Editor: William D James, MD

**Decision rationale:** The request for a medical clearance is not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. While the MedScape article does support preoperative evaluation to stratify the preoperative risk and reduce surgical complications, in this case, the surgeries in question have been denied. Therefore, the request is not certified.

**assistant surgeon:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.facs.org/ahp/pubs/2011physasstsurg.pdf>. American College of Surgeons Physicians as Assistants at Surgery: 2011 Study 2011 Assistant at Surgery Consensus Exploration of spinal fusion.

**Decision rationale:** The proposed assistant surgeon is also not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. While the American College of Surgeons (ACS) Guidelines on Physicians as Assistants at surgery does state that a spinal fusion exploration surgery "almost always" requires an assistant. In this case, the exploratory spinal fusion surgery proposed was not certified. Therefore, there is no role for an assistant surgeon here.

**Three (3)- four (4) days of inpatient days:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Integrated Treatment/Disability Duration Guidelines, Low Back Problems

**Decision rationale:** The proposed three to four day inpatient stay is also not medically necessary, medically appropriate, or indicated here. Again, the MTUS does not address the topic of hospital length of stay. While the ODG low back chapter does state that the best practice target following planned fusion surgery is three days, in this case, again, the surgery in question has been denied. There is therefore, no rule for a hospitalization here.