

<b>Case Number:</b>	CM14-0009017		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	11/21/2000
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	01/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 Anesthesiology and Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 62 year old female with complaints of low back pain. Electrodiagnostic studies completed on 08/14/13 revealed findings consistent with an acute left lumbosacral radiculopathy at the L5-S1 level. The case notes do indicate the injured worker having two previous back surgeries. The clinical note dated 11/13/13 indicates the injured worker complains of numbness and burning in the left foot. The clinical note dated 12/19/13 indicates the injured worker able to function with ongoing use of Norco. The injured worker was able to demonstrate 5/5 strength upon exam. Tenderness was identified upon palpation at the lateral region of the left ankle. The clinical note dated 01/06/14 indicates the injured worker initially injuring her low back when she was working with a quadriplegic patient. The initial injury occurred on 11/24/2000. The pain management consultation note dated 01/06/14 indicates the injured worker complaining of back, hip and leg pain. The injured worker rated the pain as 8/10. The note indicates that the injured worker utilizes Norco for ongoing pain relief. The injured worker has previously undergone physical therapy. The note indicates the injured worker being recommended for spinal cord stimulator trial. The injured worker is complaining of radiating pain from the low back to both lower extremities. The psychological assessment dated 01/22/14 indicates the injured worker being endorsed as a candidate for spinal cord stimulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRIAL SPINAL CORD STIMULATION:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, SPINAL CORD STIMU.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, SPINAL CORD STIMULATORS, Page(s): 105-106.

**Decision rationale:** The request for a spinal cord stimulator trial is certified. The documentation states the injured worker having previously undergone two back surgeries. Additionally, the injured worker has undergone injections and physical therapy as well as a psychological evaluation. A spinal cord stimulator trial is indicated for injured workers with failed back syndrome who have exhausted all conservative treatments. Given the injured worker's ongoing complaints of low back pain and taking into account the injured worker's past surgical history involving two previous surgeries, as well as the previous completion of conservative treatment, this request is reasonable. The request is medically necessary and appropriate.

**CHEST X-RAY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS ODG, Pulmonary Chapter, X-ray.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wall, B.F.; and Hart, D. (1997). Revised Radiation Doses for Typical X-Ray Examinations. The British Journal Of Radiology 70: 437-439, Retrieved 18 May 2012; and Fischbach FT, Dunning MB III, eds. (2009). Manual of Laboratory and Diagnostic Tests, 8th ed. Philadelphia: Lippincott Williams and Wilkins.

**Decision rationale:** No information was submitted regarding the need for a chest x-ray. No information was submitted regarding the injured worker's cardiac or circulatory compromise. No information was submitted regarding the injured worker's respiratory involvement. Therefore, it does not appear that a chest x-ray would be indicated for this injured worker at this time. The request is not medically necessary and appropriate.

**OFFICE VISITS X6 MONTHLY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Office Visits.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 503.

**Decision rationale:** The request for 6 monthly office visits is non-certified. There is no indication the injured worker will benefit from ongoing 6 office visits over a 6 month course. There is an indication the injured worker has ongoing complaints of pain; however, it is unclear if the patient will respond to treatments in a 6 month time frame. Therefore, this request is not indicated as medically necessary.

