

Case Number:	CM14-0100214		
Date Assigned:	08/06/2014	Date of Injury:	07/19/2006
Decision Date:	10/03/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/30/2014

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, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 49-year-old female with a 7/19/06 date of injury. At the time (5/2/14) of request for authorization for Urine Drug Screen retro, Spinal Cord Stimulation Trial, Functional Restoration Program Evaluation, and MRI Spine, there is documentation of subjective (neck pain radiating to arm and hands associated with numbness and tingling on the hand and finger tips) and objective (decreased right shoulder, elbow and wrist range of motion, tactile allodynia over the medial aspect of the right elbow, decreased pinprick sensation over the right hand, positive Tinel's sign, and decreased grip strength) findings, current diagnoses (carpal tunnel syndrome, cubital tunnel syndrome, and chronic right wrist pain), and treatment to date (medications (including Gralise, Lyrica, and Celebrex), injections, aquatic therapy, treatment with TENS unit, and physical therapy). Medical report identifies that the requested MRI Spine is for the cervical spine and to have an anatomical picture for the placement of spinal cord stimulator trial leads. Regarding Urine drug screen, there is no documentation of abuse, addiction, or poor pain control in patient under on-going opioid treatment. Regarding Spinal cord stimulation trial, there is no documentation of failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), primarily lower extremity pain, less invasive procedures have failed or are contraindicated, and a psychological evaluation prior to a trial. Regarding Functional restoration program, there is no documentation that there is an absence of other options likely to result in significant clinical improvement; the patient has a significant loss of ability to function independently resulting from the chronic pain; and the patient is not a candidate for surgery where surgery or other treatments would clearly be warranted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine Drug Screen Retro: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of abuse, addiction, or poor pain control in patient under on-going opioid treatment, as criteria necessary to support the medical necessity of Urine Drug Screen. Within the medical information available for review, there is documentation of diagnoses of carpal tunnel syndrome, cubital tunnel syndrome, and chronic right wrist pain. However, there is no documentation of abuse, addiction, or poor pain control in patient under on-going opioid treatment. Therefore, based on guidelines and a review of the evidence, the request for Urine Drug Screen retro is not medically necessary.

Spinal Cord Stimulation Trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator (SCS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators Page(s): 38.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), primarily lower extremity pain, less invasive procedures have failed or are contraindicated, and a psychological evaluation prior to a trial, as criteria necessary to support the medical necessity of spinal cord stimulation in the management of failed back syndrome. Within the medical information available for review, there is documentation of diagnoses of carpal tunnel syndrome, cubital tunnel syndrome, and chronic right wrist pain. However, there is no documentation of failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), primarily lower extremity pain, less invasive procedures have failed or are contraindicated, and a psychological evaluation prior to a trial. Therefore, based on guidelines and a review of the evidence, the request for Spinal Cord Stimulation Trial is not medically necessary.

Functional Restoration Program Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 31-32.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; the patient has a significant loss of ability to function independently resulting from the chronic pain; the patient is not a candidate where surgery or other treatments would clearly be warranted; and the patient exhibits motivation to change, as criteria necessary to support the medical necessity of chronic pain program evaluation. Within the medical information available for review, there is documentation of diagnoses of carpal tunnel syndrome, cubital tunnel syndrome, and chronic right wrist pain. In addition, there is documentation that previous methods of treating chronic pain have been unsuccessful and the patient exhibits motivation to change. However, given documentation of the requested Spinal Cord Stimulator, there is no documentation that there is an absence of other options likely to result in significant clinical improvement; the patient has a significant loss of ability to function independently resulting from the chronic pain; and the patient is not a candidate for surgery where surgery or other treatments would clearly be warranted. Therefore, based on guidelines and a review of the evidence, the request for Functional Restoration Program Evaluation is not medically necessary.

MRI Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines online edition http://www.odg-twc.com/odgtwc/low_back.htm#MRIs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183.

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure; as criteria necessary to support the medical necessity of an MRI. Within the medical information available for review, there is documentation of diagnoses of carpal tunnel syndrome, cubital tunnel syndrome, and chronic right wrist pain. In addition, there is documentation of a request for MRI Spine is for the cervical spine and to have an anatomical picture for the placement of spinal cord stimulator trial leads. However, there is no documentation of a pending spinal cord stimulator trial that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for MRI Spine is not medically necessary.