MAXIMUS Federal Services

Case Number:	CM14-0014474		
Date Assigned:	02/28/2014	Date of Injury:	06/09/2008
Decision Date:	07/03/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	02/05/2014

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 & Rehabilitation 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 a reported injury date of 06/09/2009. The mechanism of injury was not provided. The injured worker's diagnoses included cervical postlaminectomy syndrome, spasmodic torticollis, cervical myopathy due to intervertebral disc disorder, pain disorder related to psychological factors, and lumbar radiculitis. The clinical note dated 12/13/2013 noted that the injured worker complained of neck pain localized to posterior cervical region that has been present for the past 3 years and is now rated 10/10. It was also noted that the pain radiates into the left upper extremity and to the top of the left shoulder. Additionally, it was noted that the injured worker has complaints of left leg weakness, interscapular pain, headaches, and spasms in the shoulders. The clinical note also noted that the injured worker is status post anterior cervical discectomy and fusion at C3 through T3 and status post fusion at L5-S1. Recent interventions included treatment with physical therapy and hot and cold packs. The clinical note also references an unofficial MRI that revealed failure at the L5-S1 level. Upon examination of the cervical spine, it was noted that range of motion was reduced, Spurling's sign was severely positive, and there was moderate asymmetric muscle size and dystonia, abnormal posturing with lateral head tilt, and moderate to severe right anterior torticollis. Upon examination of the spine, it was noted that range of motion was restricted and that there was severe left paraspinal muscle spasms at C4, C5, C6, C7, L4, L5, and S1. Examinations of the bilateral upper extremities noted restricted range of motion and muscle strength measured at 2/5. It was also noted through examination that the injured worker had decreased sensation along the dermatomal distribution L4-5 to pinprick and that lower extremity strength was measured at 4/5 on the right and 3/5 on the left. Additionally, it was noted that the injured worker was unable to do a toe walk or heel walk and that the injured worker ambulates with a rolling walker with a short stride, with her trunk anteriorly flexed 30 degrees. The

treatment plan included ordering a spinal cord stimulator, chemodenervation of the muscles, and ultrasound guidance for needle placement, and lumbar-sacral orthosis. The request for authorization was not provided within the available clinical documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

BOTOX MEDICATION FOR MYOBLOCK CHEMODENERVATION PROCEDURE QUANTITY; 2: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox; Myobloc) Page(s): 25-26.

Decision rationale: The request for Botox medication for myoblock chemodenervation procedure quantity; 2 is an axillary request for the chemodenervation procedure which is certified. As such this request is medically necessary.

CHEMODENERVATION OF MUSCLE(S);NECK MUSCLE(S) QUANTITY;1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox; Myobloc) Page(s): 25-26.

Decision rationale: The request for chemodenervation of muscles; neck muscles, quantity 1, is certified. The California MTUS guidelines state that botox may be recommended for cervical dystonia; a movement disorder of the nuchal muscles, characterized by tremor or by tonic posturing of the head in a rotated, twisted, or abnormally flexed or extended position or some combination of these positions. As it was documented that the injured worker had clincial objective findings associated with cervical dystonia to inlcude severe spasms and documented head tilt, this request is medically necessary.

ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT IN CONJUNCTION WITH CHEMODENERVATION: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox; Myobloc) Page(s): 25-26.

Decision rationale: The request for ultrasonic guidance for needle placement in conjunction with chemodenervation is an axillary request for the chemodenervation procedure which is certified. As such this request is medically necessary.

NEEDLE ELECTROMYOGRAPHY FOR GUIDANCE IN CONJUNCTION WITH CHEMODENERVATION: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The request for needle electromyography for guidance in conjunction with chemodenervation is an axillary request for the chemodenervation procedure which is certified. As such this request is medically necessary.

SPINAL CORD STIMULATOR TRIAL QUANTITY; 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Page(s): 105-107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: The request for spinal cord stimulator trial quantity: 1 is non-certified. The California MTUS Guidelines state that spinal cord stimulators may be recommended only for select patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions to include failed back syndrome, complex regional pain syndrome, postamputation pain, and spinal cord injury dysesthesias. The guidleines also state that a psychological evaultion is needed prior to attempting a trial period with a spinal cord stimulator. There is a lack of evidence within the documentation provided that the injured worker has failed less invasive procedures and/or less invasive procedures are contraindicated; as there is documented evidence that the requesting physician is attempting chemodenervation. Additionally, there is no documented evidence of psychological evaluation. As such, this request is not medically necessary.

ELECTRONIC ANALYSIS OF SPINAL CORD STIMULATOR QUANTITY; 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Page(s): 105-107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: The request for an electronic analysis of spinal cord stimulator quanty 1 is an axillary request for the spinal cord stimulator trial which is non-certified. As such this request is not medically necessary.

IMPLANTABLE NEUROSTIMULATOR ELECTRODE QUANTITY; 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Page(s): 105.107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: The request for implantable neurostimulator electrode quantity 1 is an axillary request for the spinal cord stimulator trial which is non-certified. As such this request is not medically necessary.

FLUOROSCOPIC GUIDANCE FOR SPINAL INJECTION QUANTITY; 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Page(s): 105-107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: The request for fluoroscopic guidance for spinal injection quantity 1 is an axillary request for the spinal cord stimulator trial which is non-certified. As such this request is not medically necessary.

SCS(SPINAL CORD STIMULATOR)TRANSMITTER/RECEIVER QUANTITY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Page(s): 105.107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: The request for a spinal cord stimulator transmitter/receiver quantity 1 is an axillary request for the spinal cord stimulator trial which is non-certified. As such this request is not medically necessary.

ATIVAN 1 MG QUANTITY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The request for Ativan 1 mg quantity 90 is non-certified. The California MTUS Guidelines do not recommend benzodiazepines for long term use because long term efficacy is unproven and there is a risk of dependence. The guidelines limit use to 4 weeks. There is a lack of quantifiable evidence provided in the documentation that shows this medication is providing the desired therapeutic effect. Additionally, it is documented that the injured worker has currently been prescribed this medication since at least 11/08/2008, which exceeds the guideline recommendations. Also, the quantity of the medication was not provided in the request as submitted. As such this request is not medically necessary.

NEXIUM DR 40 MG QUANTITY: 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The request for Nexium DR 40 mg quantity 30 is non-certified. The California MTUS Guidelines recommend the use of proton pump inhibitors for injured workers who are at increased risk of gastrointestinal events. There is a lack of evidence provided within the documentation that the injured worker was experiencing side effects of medication use or symptomatology that would benefit from the use of this requested medication. Also, the request as submitted failed to indicate the quantity of the medication. As such, the request is not medically necessary.

FIORICET 50-300-40 QUANTITY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbituate Containing Analgesic Agents(BCAS) Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: The request for Fioricet 50-300-40 quantity 30 is non-certified. The California MTUS Guidelines stat that barbiturates containing analgesic agents are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show clinically important enhancement of analgesic efficacy of barbiturates containing analgesic agents due to the barbiturates constitutes. This requested medication is not recommended by the guidelines. Additionally, it remains unlcear if this is an initial prescription

versus a refill. Furthermore, the request lacks a frequency. As such, this request is not medically necessary.