

Case Number:	CM14-0131067		
Date Assigned:	08/20/2014	Date of Injury:	08/06/2012
Decision Date:	10/24/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/15/2014

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 and Rehabilitation 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 injured worker is a 44-year-old female who reported an injury on 08/06/2012. The mechanism of injury was not submitted for review. The injured worker has diagnoses of radiculopathy of the lumbar spine, fibromyalgia/myositis, radiculopathy of the cervical spine, muscle spasm, and lumbar pain. Past medical treatment consists of aquatic therapy, chiropractic therapy, epidural steroid injections, physical therapy, and medication therapy. Medications include Cymbalta, Flexeril, Diazepam, Fioricet, Tramadol, Promethazine, Terocin patches, Neurontin, Percocet, Skelaxin, and Zanaflex. On 06/20/2014, the injured worker complained of low back and neck pain. Physical examination of the spine revealed that the injured worker had palpable twitch positive trigger points noted in the muscles of the head and neck. There was pain noted when the neck was flexed anteriorly. It was also noted that the injured worker had painful left lateral rotation of the cervical spine. Inspection of the thoracic spine revealed normal curvature. There was no evidence of atrophy or asymmetry. There was also no tenderness noted at the thoracic paraspinal muscles and facet joint lines. There was a palpable twitch positive trigger point in the thoracic paraspinal muscles. Range of motion of the thoracic spine was normal with both flexion and extension without pain. There was no evidence of crepitation, laxity, or instability. The medical treatment plan is for the injured worker to undergo a spinal cord stimulator. The provider feels that the injured worker has exhausted all conservative care and that the next step would be a spinal cord stimulator to help manage pain. The request for authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial x 2 Leads: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Page(s): 105-106.

Decision rationale: The request for spinal cord stimulator is not medically necessary. The California MTUS Guidelines state that implantable spinal cord stimulators are rarely used and should be reserved for patients with low back pain for more than 6 months duration who have not responded to standard non-operative or operative interventions. Indications for the use of stimulator implantation are failed back syndrome, complex regional pain syndrome, post amputation pain, postherpetic neuralgia, spinal cord injury dysesthesias, and pain associated with multiple sclerosis, as well as peripheral vascular disease. The guidelines recommend spinal cord stimulators for patients who have undergone at least 1 previous back operation and who are not a candidate for repeat surgery with symptoms of primarily lower extremity radicular pain, a psychological clearance, not current evidence of substance abuse issues, and no contraindications to a trial. Permanent placement requires evidence of 50% pain relief and medication reduction or functional improvement after the temporary trial period. The submitted documentation had no indication that the injured worker had a diagnosis of failed back surgery. It was noted in the submitted report that the injured worker had sessions of physical therapy, acupuncture, and chiropractic therapy, but there were no progress notes indicating the outcomes of such therapies. Furthermore, there was lack of evidence of psychological clearance, indicating realistic expectations and clearance for the procedure, and there were no current evidence of addressing substance abuse issues. Additionally, there were no indications of the injured worker having any other diagnoses that are congruent with the above guidelines. Given the above, the injured worker is not within the MTUS recommended guidelines for spinal cord stimulator. As such, the request is not medically necessary.

Pre-operative consult: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for preoperative consultation is not medically necessary. As the requested surgical intervention is not supported by the documentation, the requested associated service is also not supported.