

Case Number:	CM14-0027216		
Date Assigned:	06/13/2014	Date of Injury:	11/02/1999
Decision Date:	08/14/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/03/2014

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 Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 55-year-old female who reported an injury on 11/02/1999. The mechanism of injury is unknown. The injured worker complained of low back pain which radiated down the right leg. She stated that the pain was sharp and throbbing. The injured worker also noted there was numbness and tingling in the right foot. The injured worker stated that she had trouble walking and could not walk on heels and toes. She described weakness in the right leg. The injured worker also complained of right knee pain. There was no measurable pain level documented. Physical examination dated 01/06/2014 revealed that the injured worker was unable to do heel to toe and toe to heel walk. Examination of the cervical and thoracic paraspinal muscle regions revealed that strength and sensation were intact in the upper extremities bilaterally. There were no signs of atrophy. The injured worker was able to do rapid alternating movements. Examination of the lower extremities revealed normal lordosis. Tenderness to palpation on the lumbosacral region was noted. There was no tenderness to palpation along the SI joint greater trochanter. Range of motion was normal with flexion. Decreased extension and lateral rotation was noted. She had normal tone with some paraspinal muscle spasms. The injured worker showed full range of motion of hips, knees and ankles. Coordination was smooth and symmetric. Sensation was decreased to light touch right L4-5, L5-S1 distribution. Reflexes were 2+ bilaterally. No clonus in bilateral lower extremities was noted. The injured worker had a 4/5 motor strength in the right lower extremity and a 5/5 in the left lower extremity. The injured worker had a straight leg test positive on the right side at 30 degrees and 60 degrees on the left side. The injured worker also had a positive Patrick maneuver bilaterally. An MRI done on 01/15/2014 revealed mild degenerative disc disease at the L1 and L2, L2-3, L3-4, L4-5 and L5-S1. All levels were noted to have mild facet osteoarthritis. No central spinal stenosis was noted. The injured worker has diagnoses of lumbago, spinal stenosis,

unspecified region, post laminectomy, unspecified region and lumbar radiculitis. Past medical treatment include physical therapy, chiropractic care, TENS unit, topical creams, psychological therapy, psychiatric therapy, acupuncture, injections, and medication therapy. Medications include Pristiq 100 mg 1 capsule by mouth daily, OxyContin 80 mg 1 capsule 3 times a day, and oxycodone 5 mg 1 capsule 2 times a day. The current treatment plan is for the spinal cord stimulator and 1 prescription of OxyContin. The rationale was not submitted for review. The Request for Authorization was submitted on 02/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 SPINAL CORD STIMULATOR TRIAL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101, 105, 106.

Decision rationale: The request for 1 Spinal Cord Stimulator trial is not medically necessary. The injured worker complained of low back pain down the right leg. There was no measurable pain level documented. California MTUS indicates that spinal cord stimulators are recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. It further Indicates that for stimulator implantation a patient should have the diagnosis of failed back syndrome with persistent pain in patients who have undergone at least one back surgery or patients who have the diagnosis of Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD). Additionally, it recommends a psychological evaluation for a spinal cord stimulator (SCS) trial. Given the guidelines above, the injured worker is not within guidelines. The submitted reports did not support the use of a spinal cord stimulator trial at this time. Per documentation, the injured worker has had a laminectomy and continues to have pain in the lower back that radiates in the bilateral lower extremities. Guidelines state that for a spinal cord stimulator trial to start, there should be evidence of failed back syndrome patients are candidates for further surgery and that are other interventions such as analgesics, physical therapy and injections have been tried with little to no response. The injured worker has had epidural steroid injections in the past that provided over 50% relief for more than 6 months, which appears to be a successful intervention by guideline standards. Furthermore, it is unclear if the injured worker is a candidate for further surgical intervention. As such, the injured worker meets the criteria guidelines for a trial of a spinal cord stimulator. As such, the request for a spinal cord stimulator is not medically necessary.

1 PRESCRIPTION OF OXYCONTIN 80 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78 and 92.

Decision rationale: The request for 1 prescription of OxyContin 80 mg #90 is not medically necessary. The injured worker complained of low back pain down the right leg. There was no measurable pain level documented. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state there is to be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The report submitted did not show any of the above. There was no documentation rating the injured worker's pain before and after the OxyContin. There was also no mention of side effects or how long the medication worked. There was no mention as to how long the injured worker had been on the OxyContin. The MTUS Guidelines also state that there is to be the use of drug screening or inpatient treatment with issues of abuse, addiction or poor pain control. There was a submitted UA dated 12/28/2013, but no test within the last 6 months. The frequency of the medication was not provided in the request as submitted. Given the above, the request for 1 prescription of OxyContin 80 mg #90 is not medically necessary.

1 PSYCHOLOGICAL EVALUATION CLEARANCE FOR SPINAL CORD STIMULATOR: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101,105,106.

Decision rationale: Although CA MTUS guidelines do support a psychological evaluation prior to a spinal cord stimulation trial, the injured worker did not meet guideline criteria for the trial. Therefore, the request for 1 PSYCHOLOGICAL EVALUATION CLEARANCE FOR SPINAL CORD STIMULATOR is not medically necessary.