

Case Number:	CM14-0072188		
Date Assigned:	07/16/2014	Date of Injury:	10/06/2012
Decision Date:	11/24/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	05/19/2014

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 Preventive Medicine, has a subspecialty in Occupational 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 21 year old female who was injured on 10/06/2012. The injured worker is reported of complaining of pain her the lower back, and hip. The pain is throbbing and burning, constant, about 9/10, it is associated with numbness in the lower limbs; there is intermittent swelling and discoloration of both legs. The pain limits her from walking, and is limiting her from schooling and work. The pain subsided to 2/10 (85%) when she was on trial with spinal cord stimulator trial. The physical examination revealed severe pain during range of motion testing of the lumbar spine. She manifested positive compression test, but she demonstrated normal strength and sensations in the lower limbs. The injured work has been diagnosed of Lumbago and intractable low back pain, Sacroilitis, possible reflex sympathetic dystrophy. Treatments have included two epidural steroid injections, physical therapy, medications, trial of Spinal cord stimulator. At dispute are the requests for Thoracic Spinal Cord Stimulator Placement; Pre-op medical clearance; TLSO Brace; Post-op medication-Tramadol; Post-op medication-Flexeril; Post-op medication-Augmentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thoracic Spinal Cord Stimulator Placement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Spinal Cord Stimulators

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SPINAL CORD STIMULATORS (SCS) Page(s): 105-107.

Decision rationale: The injured worker sustained a work related injury on 10/06/2012. The medical records provided indicate the diagnosis of Lumbago and intractable low back pain, Sacroilitis, possible reflex sympathetic dystrophy. Treatments have included two epidural steroid injections, physical therapy, medications, and trial of Spinal cord stimulator. The medical records provided for review do not indicate a medical necessity for Thoracic Spinal Cord Stimulator Placement. Although diagnosis includes a possibility of Reflex sympathetic dystrophy, the 05/08/2014 report indicates the diagnosis has not been confirmed. Furthermore, the report indicates the injured worker discontinued the medications because of side effects, but the report did not provide the names of the medications tried or any information regarding the outcome of other medications. The guidelines recommends spinal cord stimulator only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions such as failed back surgery, reflex sympathetic dystrophy, post amputation pain.

Pre-op medical clearance: 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 SPINAL CORD STIMULATORS (SCS) Page(s): 105-107.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

TLSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The injured worker sustained a work related injury on 10/06/2012. The medical records provided indicate the diagnosis of Lumbago and intractable low back pain, Sacroilitis, possible reflex sympathetic dystrophy. Treatments have included two epidural steroid injections, physical therapy, medications, and trial of Spinal cord stimulator. The medical records provided for review do not indicate a medical necessity for TLSO Brace. The ACOEM guidelines recommends against the use of back support in for treatment of back pain.

Post-op medication-Tramadol: 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 SPINAL CORD STIMULATORS (SCS) Page(s): 105-107.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op medication-Flexeril: 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 SPINAL CORD STIMULATORS (SCS) Page(s): 105-107.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op medication-Augmentin: 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 SPINAL CORD STIMULATORS (SCS) Page(s): 105-107.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.