

Case Number:	CM14-0074984		
Date Assigned:	07/16/2014	Date of Injury:	12/12/2003
Decision Date:	09/08/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/23/2014

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 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 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 59-year-old female who reported an injury on 12/12/2003. The mechanism of injury was not provided within the documentation submitted for review. Her diagnoses were noted to be degeneration of the cervical intervertebral disc, displacement of cervical intervertebral disc without myelopathy, brachial neuritis or radiculitis, cervical region lumbago, lumbar intervertebral disc without myelopathy, thoracic or lumbosacral neuritis or radiculitis, and lumbar region. Past treatments were noted to be TENS unit and medications; diagnostics were noted to be CT scans. Surgical history was noted to be discectomy and intervertebral fusion. The injured worker's subjective complaints were noted in a Secondary Treating Physician's Progress Report dated 04/25/2014. She complained of low back pain and neck pain. The injured worker reported the spinal cord stimulator implant no longer provided significant pain relief. She described the pain as sharp, stabbing, burning, and constant. She indicated pain radiated into the bilateral legs especially at night, numbness, paresthesias and weakness was noted. The objective physical exam findings include tenderness to palpation of the paralumbar region. Atrophy was noted in the quadriceps. Deep tendon reflexes were absent at the knees. The injured worker's medications were noted to be OxyContin and Gabapentin. The treatment plans was for a new battery for IPG, current medication refills, and continue with therapeutic exercise. The provider's rationale for the request was partially provided within the treatment plan of the progress report dated 04/25/2014. A Request for Authorization form was not provided with the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Placement of new battery for Internal Pulse Generator (IPG).: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS); Indications for stimulator implantation; Spinal cord stimulators, psychological evaluations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Durable medical equipment (DME).

Decision rationale: The request for placement of a new battery for internal pulse generator is not medically necessary. The Official Disability Guidelines recommend durable medical equipment if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. However, it is noted in the progress report the injured worker stated that stimulation was not significant to provide pain relief. Therefore, without efficacy of the unit, the battery is not a medical necessity. As such, the request for placement of a new battery for internal pulse generator is not medically necessary.

Monitored anesthesia care.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS); Indications for stimulator implantation; Spinal cord stimulators, psychological evaluations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Pre Op, general.

Decision rationale: The request for monitored anesthesia care is not medically necessary. The Official Disability Guidelines state preoperative testing is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but are often obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. It is not noted that there is a surgery scheduled for the injured worker. As such, monitored anesthesia care is not a medical necessity therefore, the request for monitored anesthesia care is not medically necessary.

Epidurography.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS); Indications for stimulator implantation; Spinal cord stimulators, psychological evaluations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Triad Healthcare.

Decision rationale: The request for Epidurography is not medically necessary. Epidurography is defined as a radiologic imaging examination performed on the veins in the lining of the spinal canal. Contrast is injected into the epidural space under direct fluoroscopy, examining the flow of contrast in the epidural space around the nerves to be studied, and aiding in the diagnosis of intervertebral disc herniation, narrowing and swelling around the nerve and/or nerve roots, and compressive lesions. An Epidurography is considered necessary to identify anatomic or functional abnormalities not identified with other imaging studies such as MRI, CT scan, or a CT scan following Myelography, or if the patient has continuous epidural infusion via catheter. It is not documented that the injured worker has exhausted resources with imaging to warrant an Epidurography. It is also not noted in the progress report that the injured worker has an epidural infusion via catheter. Additional documentation is necessary to further review this request. As such, the request for Epidurography is not medically necessary.