

Case Number:	CM14-0211169		
Date Assigned:	12/24/2014	Date of Injury:	07/07/2008
Decision Date:	02/17/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/16/2014

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 Internal Medicine 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 (IW) is a 51-year-old man with a date of injury of July 7, 2008. The mechanism of injury occurred as a result of a crush injury in a printing press. The injured worker's working diagnosis is reflex sympathetic dystrophy, status post crush injury to the left hand with multiple surgeries and partial amputation. Pursuant to the progress report dated September 17, 2014, the IW is status post multiple surgeries. He has had his 4th finger amputated, and 3rd dip amputated. There have been multiple attempts at neuroma resections. The IW mentions Lyrica has been helpful. He has had a spinal cord stimulator (SCS) trial (unknown date), which had strong positional changes, but did get pain relief. Pain is described as sharp, dull, throbbing, aching, electricity and pins and needles. His pain increases with cold. His pain decreases with medications and heat. Prior treatments have included therapy, ice/heat, injections, and medications. Objectively, the IW guards his left hand. He has extensive scars and a palpable neuroma on the left palm. There is a mottles appearance with allodynia/dysesthesias. The treating physician indicated the IW apparently had a SCS trial but the IW reports problems with equipment and results were inconclusive. It is unknown how long the trial was for. There is no evidence of objective functional improvement associated with prior SCS trial. The IW has had a prior psychological evaluation. The current request is for spinal cord stimulator trial with fluoroscopy and moderate sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial with fluoroscopy and moderate sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Spinal Cord Stimulator.

Decision rationale: Pursuant to the Official Disability Guidelines, spinal cord stimulator trial with fluoroscopy and moderate sedation is not medically necessary. Spinal cord stimulator (SCS) is recommended only for selected patients with specific conditions and cases when less invasive procedures have failed or are contraindicated. SCS is indicated with complex regional pain syndrome type I. Indications for stimulator implantation are enumerated in the Official Disability Guidelines. Complex regional pain syndrome when all the following are present; limited response to nonconventional care; psychological clearance indicates realistic expectations and clearance for the procedure; evidence of substance abuse issues; no contraindications to a trial; permanent placement requires 50% pain relief and medication reduction or functional improvement after temporary trial. In this case, the injured worker's working diagnosis is reflex sympathetic dystrophy. A September 17, 2014 progress note's documentation states the injured worker had a prior spinal cord stimulator trial. Reportedly, they were strong positional changes the injured worker did get pain. There is no hard copy of the SCS trial in the medical record. Under the recommendation section, the treating physician indicated the injured worker had an SCS trial and the injured worker reported problems with the equipment and results were inconclusive. He already had a psych evaluation prior to that procedure. The treating physician wants to repeat the spinal cord stimulator trial with fluoroscopy and moderate sedation. The documentation indicates the injured worker had a prior SCS trial. The results are not in the medical record. The burden is on the treating physician to obtain the first result for an objective evaluation. Additionally, there is no psychiatry/psychological clearance in the medical records. The treating physician indicated a psychiatry/psychology evaluation was performed but the report is not a medical record. It is unclear whether the injured worker understands the realistic expectations and whether or not a clearance was provided for the procedure. Consequently, absent documentation including the prior SCS trial, the psychological/psychiatric clearance with realistic expectations and a clearance evaluation, spinal cord stimulator trial with fluoroscopy and moderate sedation is not medically necessary.