MAXIMUS Federal Services

Case Number:	CM15-0008916		
Date Assigned:	01/26/2015	Date of Injury:	01/08/2009
Decision Date:	03/24/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 43-year-old male who reported an injury on 01/08/2009. The mechanism of injury was not specifically stated. The current diagnoses include cervical sprain, shoulder sprain, lumbar sprain, and knee sprain. The latest physician progress report submitted for review is documented on 12/05/2014. The injured worker presented with complaints of 8/10 low back pain and 7/10 left knee and right shoulder pain. Previous conservative treatment includes medications, ice therapy, and H wave stimulation. Upon examination, there was decreased lumbar range of motion, tenderness to palpation, muscle spasm, decreased range of motion of the right shoulder, tenderness at the anterior/posterior aspect, decreased range of motion of the left elbow, and tenderness at the medial and lateral epicondyle. The injured worker was also noted to be status post lumbar epidural injection on 07/02/2013. Treatment recommendations at that time included continuation of the home exercise program, multiple followup visits, triggerpoint injections, and a return visit in 1 month for pain management. There was no Request for Authorization form 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 with Spine surgeon approval - Discuss with spine surgeon on 1/7/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 101. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101 and 105-107..

Decision rationale: California MTUS Guidelines recommend spinal cord stimulators only for selected patients in cases when less invasive procedures have failed or are contraindicated. Guidelines recommend a psychological evaluation prior to a spinal cord stimulator trial. In this case, there was no documentation of psychological clearance. Additionally, it is noted that the injured worker has been recommended to begin a course of physical therapy for the low back. Given documentation of the request for physical therapy, there is no documentation of a limited response to additional noninterventional care. Given the above, the request is not medically appropriate at this time.

Associated surgical service: Physical therapy 3x4 for the neck, back, left knee and right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical therapy

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

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

Associated surgical service: Ortho for local injection fore the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for steroid injections

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

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