

Case Number:	CM15-0103917		
Date Assigned:	06/08/2015	Date of Injury:	03/05/2007
Decision Date:	07/13/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	05/29/2015

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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

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 44 year old female who sustained an industrial injury on 3/5/07 from driving a stand up cart and developed cumulative injury to her low back. She initially was provided with pain medication and physical therapy, which was of no benefit. She currently complains of low back and left lower extremity pain radiating to the toes with pain level of 9/10. She has difficulty sleeping and with navigating steps to her front door. On physical exam there was positive left, positive Bowstring Sign on the left straight leg raise, positive Fabers on the left. Medications are orphenadrine citrate, naproxen, Topamax, omeprazole, marijuana suckables, Lyrica, Elavil, gabapentin. Diagnoses include failed back surgery, status post L5-S1 fusion (2/11/08); facet arthropathy of the lumbar spine with radicular symptoms; lumbago; adjustment disorder; left sacroiliitis; lumbago. Treatments to date include aqua therapy with mild relief; transcutaneous electrical nerve stimulator unit, which increased the pain; medial branch block of L3-4, L4-5 (4/30/14) which provided 3-4 hours of relief; multiple physical therapy sessions with no improvement. Diagnostic include electromyography of the bilateral lower extremities (7/17/14); MRI of the lumbar spine (5/17/13) showing post-operative changes and mild bilateral foraminal narrowing. In the progress note dated 4/6/15 the treating provider's plan of care includes requests for spinal cord stimulator trial and modification to the stairs of her home. The 3/27/2015 Psychology report noted ongoing severe depression. The diagnosis was major depression and Bipolar. It was recommended that IW undergo 1 year psychology treatment and medication management. On 4/6/2015, the IW reported that she had discontinued all medications because of possible side effects of mood swings and high glucose levels. The IW

reported that she was feeling much better. The assistant of In-Home healthcare and Occupational therapy was recently approved for the IW.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial Qty: 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations, IDDS & SCS (Intrathecal drug delivery & spinal cord stimulators) Page(s): 101, 105-108.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101, 105-107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Spinal Cord Stimulator (SCS) can be utilized for the management of severe low back pain when conservative treatments with medications, PT, minimally invasive pain injections and surgery have failed. The records indicate that the patient reported symptomatic improvement after discontinuation of all pain medications. The patient was diagnosed with ongoing severe depression but is non-compliant with prescribed antidepressant medication. The Psychologist did not clear the patient for SCS but recommended 1 year of therapy and medications management. The criteria for Spinal Cord Stimulator trial #2 was not medically necessary.

Home modification of stairs to mobile home, shorten them to 4" and include a railing for easy access Qty: 1.00: 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 9792.21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low Back and Other Medical Treatment Guidelines CMS - Medicare.

Decision rationale: The CA MTUS did not address the modification of home structures for the treatment of musculoskeletal pain. The ODG and the CMS guidelines noted that durable medical equipment and Home Assistants can be utilized to improve mobility and improve or restore physical function. The records did not show a detail analysis of current incapacitation or decreased mobility cause by the current status of the home stairs. The recently approved In-Home healthcare and Occupational therapy have not been completed. The criteria for Home modification of stairs to mobile home, shorten them to 4" and include a railing for easy access Qty 1 was not medically necessary.

