

<b>Case Number:</b>	CM15-0201942		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	11/21/2011
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	10/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: New York, Montana,  
 California Certification(s)/Specialty: Neurological  
 Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 60 year old male with a date of injury of November 21, 2011. A review of the medical records indicates that the injured worker is undergoing treatment for complex regional pain syndrome, contusion of the upper limb, fibromyalgia-myositis, shoulder joint pain, and unspecified neuralgia neuritis and radiculitis. Medical records dated June 2, 2015 indicate that the injured worker complained of more left shoulder pain lately, and severe left arm and hand pain. A progress note dated July 29, 2015 documented complaints of moderate pain in the left arm, headaches, and sensitivity in the left upper extremity. The physical exam dated June 2, 2015 reveals decreased range of motion of the cervical spine with pain, dysesthesia of the left hand that is improved, decreased grip strength, left shoulder tenderness at the acromioclavicular joint, pain with reaching behind the back, allodynia and dysesthesia of the left arm, and upper back trigger points and myospasm in the trapezius. Treatment has included medications (Meloxicam and Neurontin), and transcutaneous electrical nerve stimulator unit. There is no documentation of prior diagnostic testing in the submitted records. The original utilization review (October 2, 2015) non-certified a request for implantation of a spinal cord stimulator and associated services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Spinal Cord Stimulator x 2 Leads: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines 2009 do recommend spinal cord stimulators for CRPS. Documentation however shows the patient is ambivalent about the implantation. More significantly documentation does not show failures in medication trials or prior diagnostic testing to verify the diagnosis and failures in treatment. The requested treatment: Spinal Cord Stimulator x2 Leads is not medically necessary and appropriate.

**Pre-Operative Medical Clearance to include History & Physical: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary, Online Version, Preoperative testing.

**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.

**Pre-Operative EKG: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary, Online Version, Preoperative testing.

**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.

**Pre-Operative Labs: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary, Online Version, Preoperative testing.

**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.