

<b>Case Number:</b>	CM15-0052873		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	06/24/2011
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2015

### 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: Illinois, California, Texas

Certification(s)/Specialty: Orthopedic 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:

The injured worker is a 48-year-old female who sustained an industrial injury on 6/24/11. Injury occurred when she reached above her head to grab a product and experienced intense right shoulder blade pain which resulted in upper extremity numbness and tingling, and chest and abdominal pain. Past medical history was positive for diabetes. Past surgical history was positive for right carpal tunnel release on 1/24/12. She was diagnosed with reflex sympathetic dystrophy of the right upper extremity. Psychological evaluation was provided on 10/28/14 with psychological treatment recommended. There were no follow-up reports in the submitted documents. The 2/13/15 treating physician report cited grade 7/10 right shoulder and arm pain. Pain was constant and radiating, and increased by hand use. Pain was characterized as sharp, burning, aching, electricity, and pins and needles. Gabapentin had been denied and abruptly stopped resulting in significant dysphoria and side effects. Tizanidine and Cymbalta were helpful. Physical exam documented allodynia and dysesthesias right hand, decreased right hand temperature relative to the left, mottled appearance of right hand, and weak right grip. Psychological findings were positive for depressed and flat affect. The diagnosis was complex regional pain syndrome right upper extremity status post carpal tunnel release. The injured worker had undergone 2 stellate ganglion blocks with only 3 weeks relief of paresthesias and swelling. She had severe neuropathic pain that had failed medication, physical therapy, TENS unit, and stellate ganglion blocks. Medications included Lidoderm patches, Percocet, Fentanyl, tizanidine, and Cymbalta. She had pre-trial clearance from her psychologist. Authorization was requested for spinal cord stimulator trial under fluoroscopy with MAC (monitored anesthesia

care). The 3/6/15 treating physician report indicated the patient had significant clinical worsening with grade 10/10 pain that reduced to 6-7/10 with medication. Exam findings were unchanged. The 3/9/15 utilization review non-certified the request for spinal cord stimulator under fluoroscopy with MAC as psychological clearance was not evidenced in the records.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Spinal cord stimulator under fluoroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

**Decision rationale:** The California MTUS recommend the use of spinal cord stimulator only for selected patients in cases when less invasive procedures have failed or are contraindicated. Indications included failed back syndrome, defined as persistent pain in patients who have undergone at least one previous back surgery, and complex regional pain syndrome. Consideration of permanent implantation requires a successful temporary trial, preceded by psychological clearance. Guideline criteria have not been met. This injured worker presents with a diagnosis of right upper extremity complex regional pain syndrome and has failed comprehensive conservative treatment. She underwent a psychological consult on 10/28/14 that recommended psychological treatment. There are no follow-up psychological reports indicating that she was cleared for spinal cord stimulator trial. In the absence of this documentation, this request is not medically necessary.

**MAC for the right wrist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.