

Case Number:	CM14-0121968		
Date Assigned:	09/16/2014	Date of Injury:	12/24/2009
Decision Date:	10/16/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/01/2014

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 Physical Medicine and Rehabilitation 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 patient is a 51-year-old male who has submitted a claim for chronic pain, post laminectomy syndrome, and lumbar degenerative dis disease associated with an industrial injury date of 12/24/2009. Medical records from 09/11/2012 to 07/10/2014 were reviewed and showed that patient complained of low back pain radiating down bilateral legs. There was no complaint of upper back pain. Physical examination revealed well-healed multiple major laminectomy scars, tenderness and muscle guarding over lumbar paraspinals, limited lumbar ROM, hypesthesia along L5 and S1 distribution bilaterally, and intact DTRs and MMT of lower extremities. Complete evaluation of the thoracic spine was not made available. MRI of the lumbar spine dated 11/2012 revealed L5-S1 herniated disc. EMG/NCV study of lower extremities dated 04/22/2011 revealed left L5 radiculopathy. Of note, there was no discussion of failed back syndrome, complex regional pain syndrome (CRPS)/reflex sympathetic dystrophy (RSD), post amputation pain (phantom limb pain), post herpetic neuralgia, or spinal cord injury dysesthesias. Treatment to date has included lumbar microdiscectomy (2010), L4-5 and L5-S1 interbody fusions (09/19/2012), laminectomy (04/2013), spinal cord stimulator implantation (03/2014), physical therapy, and pain medications. Of note, there was no documentation of functional outcome concerning spinal cord stimulation implant, physical therapy, and pain medications. Utilization review dated 07/21/2014 denied the request for MRI of the thoracic spine because there was no clinical rationale provided for the procedure. Utilization review dated 07/21/2014 denied the request for Spine Cord Stimulator (SCS) Implant with 3 Leads because possible illicit drug use and opioid dependence were contradictory to spinal cord stimulator trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spine Cord Stimulator (SCS) Implant with 3 Leads: Upheld

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

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

Decision rationale: According to pages 105 to 107 of the CA MTUS Chronic Pain Medical Treatment Guidelines, spinal cord stimulators are recommended only for cases when less invasive procedures have failed or are contraindicated. Indications for stimulator implantation include: failed back syndrome; Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD); post amputation pain (phantom limb pain); Post herpetic neuralgia; spinal cord injury dysesthesias; pain associated with multiple sclerosis and peripheral vascular disease. In this case, the patient complained of chronic low back pain which prompted spinal cord stimulator trial (03/2014). However, there was no documentation of functional outcome from previous SCS trial. Moreover, there was no documentation of functional outcome from previous physical therapy or pain medications to provide evidence of treatment failure. The guidelines only recommend SCS for cases where less invasive procedures have failed. The aforementioned circumstances for which SCS were indicated were not present in this case. There is no clear indication for a repeat SCS at this time. Therefore, the request for Spine Cord Stimulator (SCS) Implant with 3 Leads is not medically necessary.

MRI - Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 178-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI

Decision rationale: As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for the lumbar spine for uncomplicated low back pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe, or progressive neurologic deficit. In this case, there were no subjective complaints of upper back / thoracic pain. Moreover, complete evaluation of the thoracic spine was not available. The medical necessity cannot be established due to insufficient information. Therefore, the request for MRI - Thoracic Spine is not medically necessary.

