

Case Number:	CM14-0210834		
Date Assigned:	12/23/2014	Date of Injury:	07/17/2007
Decision Date:	02/27/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabn

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 41 year old female with date of injury 07/17/07. The treating physician report dated 10/8/14 (28) indicates that the patient presents with pain affecting the neck and upper back. The patient complains of worsening morning headaches. The physical examination findings reveal tenderness to palpation over the posterior cervical paraspinal muscles, is slightly worse on the right than the left. There is also guarding with palpation of the left upper trapezius. The range of motion of the cervical spine is limited. Further examination reveals tenderness to palpation and guarding over the left shoulder AC joint. Range of motion of the lumbar spine is limited and is accompanied with pain in all directions. Prior treatment history includes a psychiatric consultation, a TENS unit, TMS therapy (7sessions), a 6 month pool membership, a CESI, and prescribed medications. Current medications include pantoprazole, nabumetone, Prozac, Gabapentin, Orphenadrine, Alprazolam, Abilify and topical diclofenac. MRI findings of the cervical spine reveal mild degenerative disc disease with straightening of normal cervical lordosis, a C5-6 bulge with dorsal annular fissure, mild canal narrowing and mild left neural foraminal narrowing, and a C3-4 small left paracentral to foraminal disc protrusion, mild canal narrowing on the left. The current diagnoses are: 1. Pain in joint shoulder2. Cervical disc displacement without myelopathy3. Syndrome cervicobrachial4. Depression5. Pain in limbThe utilization review report dated 11/12/14 denied the request for Transcranial magnetic stimulation, twice weekly for ten weeks based on a lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcranial magnetic stimulation, twice weekly for ten weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Transcranial magnetic stimulation (TMS), Mental Illness/Stress, Transcranial magnetic stimulation (TMS)

Decision rationale: The patient presents with pain affecting the neck and upper back, accompanied with severe depression. The current request is for Transcranial magnetic stimulation, twice weekly for ten weeks. The requesting treating physician report was not found in the documents provided. The UR report dated 11/12/14 (7) notes, "MD confirms in review that Transcranial magnetic stimulation was recommended, since the patient had only partial response to an adequate trial of Fluoxetine, had failed multiple trials with other antidepressants with pharmacological and psychotherapeutic augmentations, and would not like to increase the dose of Fluoxetine or add other psychotropic medications due to possible side effects." An initial psychiatric evaluation report dated 10/3/14 (78) states, "The patient obtained a total score of 26 in the depression inventory. This may suggest severe clinical depression." The MTUS guidelines do not address the current request. The ODG guidelines criteria for Transcranial magnetic stimulation (TMS) for the treatment of severe depression is as follows: "- Failure of at least 3 different medication trials, from at least 2 different classes, at adequate dose and duration or due to intolerable effects, plus - Failure of a trial of electroconvulsive therapy (ECT) due to inadequate response or intolerable effects or bona-fide contraindication to ECT, OR - Failure of at least 4 different antidepressant medication trials, from at least 2 different classes, at adequate dose and duration or due to intolerable effects, OR - A positive clinical response to a previous course of treatment with TMS." In this case, the UR report notes that the patient had 7 previous TMS sessions and achieved no improvement in symptoms. Furthermore, there is a lack of documentation of a failed ECT trial in the reports provided. The patient did not receive a positive clinical response to a previous course of treatment with TMS and has not failed a trial of electroconvulsive therapy, therefore the current request does not satisfy the required criteria outlined by the ODG guidelines. Recommendation is for denial.