

Case Number:	CM15-0070113		
Date Assigned:	04/20/2015	Date of Injury:	02/14/2010
Decision Date:	05/27/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	04/14/2015

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: 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 62 year old female who sustained an industrial injury on February 14, 2010. Prior treatment includes imaging of the cervical spine, L4-L5 lumbar fusion, epidural steroid injection, and medications. Currently the injured worker complains of neck pain and grinding his teeth at night. He has low back pain and lower leg pain. Diagnoses associated with the request include spondylosis of L5-S1, cervical disc degeneration, cervical spondylosis, post laminectomy lumbar fusion syndrome, depression and anxiety disorder. The treatment plan includes L3-4 facet injection, medications, spinal cord stimulator trial, cane and new lumbosacral orthosis. On 12/8/2014, the IW was noted to have failed spinal cord stimulator trial. An intrathecal pump or repeat surgery was being considered as the next option. There was previous documentation of objective findings of positive Waddell's sign and non-dermatomal sensory loss of the lower extremities. The medications listed are Norco, Nucynta, Neurontin, Flexeril, Exedrin and Cymbalta.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable medical equipment (DME) spinal cord stimulator (SCS) trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Spinal Cord Stimulators Page(s): 107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 101, 105-107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Upper Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that spinal cord stimulator (SCS) treatment can be option for the treatment of severe musculoskeletal pain when conservative treatments with medications and PT have failed and surgical and minimally invasive interventional pain injections have been exhausted. It is required that the presence of symptomatic psychosomatic disorders be excluded because of decreased efficacy with SCS treatment in patient with significant psychiatric condition. The records did not show that optimum medications treatment have failed. There are significant psychosomatic symptoms that had not been treatments effectively or cleared by the mental health providers. There is documentation that the SCS trial already completed but was unsuccessful. The criteria for spinal cord stimulator trial was not met, therefore the request is not medically necessary.

Facet injection, C5-6 & L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174, 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, Neck and upper back chapter, Facet joint diagnostic blocks: Low Back chapter, Facet joint diagnostic blocks (injections).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.29.59792.23.1 Page(s): 46, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Neck and Upper Back Low and Upper Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that intervention pain procedures can be utilized for the treatment of severe musculoskeletal pain that did not respond to conservative treatment with medications and PT. The records indicate that the neck pain was noted have decreased significantly to 3/10 following the last cervical epidural injection. There is not documentation of subjective, objective or radiological findings confirming the spine pain to be of facet origin. The symptoms are indicative of cervical and lumbar radicular pain. The presence of significant psychosomatic symptoms is associated with decreased efficacy of intervention pain procedures. The guidelines do not support cervical and lumbar facet procedures to be performed together at one setting. The criteria for C5-C6 and L3-L4 facet injections was not met, therefore the request is not medically necessary.

Durable medical equipment (DME) lumbosacral orthosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Upper Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Durable Medical Equipment (DME) can be utilized for immobilization or to improve function in patients with severe musculoskeletal dysfunction. The guidelines noted that there is no significant beneficial effect with utilization of DME beyond the acute back injury phase. The records did not show subjective or objective findings indicating severe limitation of physical functions that can be improved by utilization of DME. The criteria for the use of durable medical equipment (DME) lumbosacral orthosis was not met, therefore the request is not medically necessary.