

Case Number:	CM15-0097862		
Date Assigned:	05/28/2015	Date of Injury:	11/30/2010
Decision Date:	07/08/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/20/2015

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 53-year-old female who sustained an industrial injury on 11/30/10. Injury occurred when she tripped over a bag on the floor and landed on her back with her left leg under her body. Past surgical history was positive for L5/S1 fusion in 1998, open reduction internal fixation left hip in March 2013, and bilateral L4/5 and L3/4 neural foraminotomies and L4/5 discectomy with posterior interbody fusion on 7/24/13. The 2/10/15 initial pain management report cited constant low back pain radiating down both legs, worse on the right, with numbness in the toes on both feet. She reported constant right hip pain and intermittent left ankle pain. She had pain with walking, sitting, and standing. She was able to perform a partial squat with pain. Physical exam documented slow deliberate gait with broad based gait. She walked on her toes and heels with great difficulty. Lumbar range of motion was limited in all planes, positive bilateral straight leg raise, positive Lasegue's test, positive Trendelenburg testing, and restricted bilateral hip and ankle range of motion. The diagnosis was musculoligamentous sprain lumbar spine with lower extremity radiculitis. Treatment options were discussed to include spinal cord stimulator, medications, therapy, and epidural injection. Authorization was requested for lumbar spine MRI, spinal cord stimulator trial, and lumbar brace. The 4/18/15 spinal cord stimulator trial report cited grade 8/10 low back pain radiating down both lower extremities. The diagnosis was lumbar degenerative disc disease, failed back surgery syndrome, and neuropathy. She had undergone multiple epidural steroid injections and a trial of caudal epidural adhesion lysis which was not helpful. She underwent a spinal cord stimulator trial under fluoroscopy with placement of peripheral electrodes. She tolerated the

procedure well without complication. Spinal cord stimulator trial was planned for 4-7 days, If 70-80% pain reduction was achieved, will proceed to permanent implantation. Authorization was requested on 4/25/15 for outpatient surgery for permanent spinal cord stimulator placement, with associated surgical requests including motorized wheelchair and physical therapy for the lumbar spine 2x6. The 5/4/15 utilization review non-certified the request for motorized wheelchair as guideline criteria had not been met for a powered mobility device. The request for permanent spinal cord stimulator placement was non-certified as there was no documentation of psychological clearance and no detailed documentation of medication reduction or functional improvement after temporary trial. The request for physical therapy 2x6 for the lumbar spine was non-certified as there was no documentation of the number of previous physical therapy treatments, functional improvement with previous treatment, and rationale for why residual deficits could not be resolved in the context of a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Motorized wheel chair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 132. Decision based on Non-MTUS Citation ODG Ankle & Foot Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Power mobility devices (PMDs).

Decision rationale: The California MTUS guidelines do not provide recommendations for motorized wheelchairs. The Official Disability Guidelines state that power mobility devices (PMDs) are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. Guideline criteria have not been met. There was no assessment of functional mobility documented in the submitted medical records. The pain management initial report, the injured worker was reported with a slow deliberate gait and broad based stance. There was no documentation of any upper extremity functional loss that would preclude her ability to propel a manual wheelchair should a cane or walker be insufficient. Therefore, this request is not medically necessary.

Outpatient surgery for permanent spinal cord stimulator placement: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101, 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 underwent spinal cord stimulator trial on 4/18/15 with no subsequent documentation relative to the degree of improvement achieved, relative to VAS improvement, pain medication reduction, or functional benefit. Although the trial has already taken place, there is no documentation of psychological clearance. Therefore, this request is not medically necessary at this time.

Associated Surgical Service: Physical Therapy for the lumbar spine 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, Physical Medicine Page(s): 9, 98-99.

Decision rationale: The California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. In general, guidelines would support up to 10 physical therapy visits for a diagnosis of low back pain with lower extremity radiculitis. Guideline criteria have not been met. There is no documentation of functional treatment goals for the requested physical therapy. There is no functional assessment or specific functional deficit identified. There is no documentation relative to prior physical therapy and what, if any, objective measurable functional improvement was achieved. There is no compelling rationale to support the medical necessity of supervised physical therapy over an independent home exercise program for this injured worker. Therefore, this request is not medically necessary.