

<b>Case Number:</b>	CM13-0011158		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	11/10/1999
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	07/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & 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 physician 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 64-year-old female who reported an injury on 11/10/1999. The patient was noted to be status post lumbar spine surgery times 4. The patient was noted to have continued low back pain at 10/10. The diagnosis was noted to include status post lumbar spine surgery times four. The request was made for spinal cord stimulator trial surgery, pre-op clearance, post-op physical therapy three (3) times a week for four (4) weeks, and an LSO Brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Spinal cord stimulator trial surgery:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Section Page(s): 106-107.

**Decision rationale:** The California MTUS Guidelines recommend a Spinal cord stimulators are recommended for patients when less invasive procedures have failed or are contraindicated and for patients who have failed back syndrome. The recommendations indicate that there should be a psychological evaluation prior to a spinal cord stimulator trial. The clinical documentation submitted for review indicated the patient had failed back syndrome. It indicated the patient had

pain at a 10/10. However, the clinical documentation submitted for review failed to provide the patient had a thorough objective psychological evaluation prior to the requested implantation. Given the above, the request for a spinal cord stimulator trial surgery is not medically necessary.

**Pre-op clearance is not medically necessary and appropriate:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Society of General Internal Medicine

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary

**Post op physical therapy three (3) times a week for four (4) weeks is not medically necessary and appropriate.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**LSO brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Back Brace, Post-Operative (fusion).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Hot/Cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Hot/Cold Packs.

**Decision rationale:** The California MTUS/ACOEM Guidelines address cold packs; however, do not address hot and cold therapy. The Official Disability Guidelines recommend application of cold and heat packs as an option for acute pain. The clinical documentation submitted for review failed to provide the necessity for the requested hot and cold therapy unit as it is indicated per Official Disability Guidelines that at home applications of cold packs in the first few days of acute complaint and thereafter, applications of heat packs or cold packs are sufficient. Given the above, the request for hot cold therapy unit is not medically necessary.