MAXIMUS Federal Services

Case Number:	CM13-0014625		
Date Assigned:	10/04/2013	Date of Injury:	02/23/1997
Decision Date:	07/23/2014	UR Denial Date:	08/13/2013
Priority:	Standard	Application Received:	08/22/2013

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, has a subspecialty in Interventional Spine, 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:

This patient is a 47-year-old male with date of injury 02/23/1997. Per treating physician's report on 08/06/2013, the assessments are: failed back surgery syndrome lumbar region, displacement of lumbar intervertebral disk without myelopathy, lumbosacral radiculitis, displacement of thoracic intervertebral disk without myelopathy, and pain in thoracic area. The presenting symptoms are low back pain with radiculopathy that radiates into the right thigh, numbness and pain in the L3-L4 distribution, worse for the past 6 days causing weakness and significant pain. The examination showed normal range of motion with pain, straight leg raise test negative bilaterally, strength within normal limits, sensation reduced in S1 nerve distribution on the right, and antalgic gait. The recommendation was for spinal cord stimulator and pending psychological evaluation. Computed tomography (CT) myelogram was recommended. Due to pain in the right lower extremity, recommend transforaminal epidural steroid injection (ESI) at L3-L4. Under diagnostic studies, a lumbar CT from 02/09/2010 showed mild spinal stenosis at T12-L1, osteophyte or hard disk at T12-L1, postoperative changes at L4-L5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

PSYCHOLOGICAL EVALUATION FOR SPINAL CORD STIMULATOR: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS), Psychological treatment Page(s): 101, 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.1.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions, Psychological treatment, Spinal cord stimulators (SCS) Page(s): 23, 101, 102.

Decision rationale: This patient presents with diagnosis of post-laminectomy syndrome with persistent pain in low back with radiation down the lower extremity. MRI (magnetic resonance imaging) from 02/09/2010 reportedly showed postoperative changes at L4-L5, L5-S1, hard disk/osteophyte at T12-L1. The treating physician has asked for a psychological evaluation to consider spinal cord stimulation. The MTUS Guidelines states under spinal cord stimulation, "recommended for patients in cases where less invasive procedures have failed or are contraindicated." Specific indications for stimulator implantations are "failed back surgery syndrome (persistent pain in patients who have undergone at least 1 previous back operation), more helpful for lower extremity than low back pain although both stand to benefit." This patient does have failed back surgery syndrome, with prior laminectomies at L4-L5, L5-S1. The patient has persistent pain down the lower extremity and low back. Thus, psychological evaluation for spinal cord stimulation is reasonable. The recommendation is for authorization.

COMPOUND CREAM (UNSPECIFIED): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics Page(s): 111-113.

Decision rationale: This patient presents with chronic low back and lower extremity pain with a diagnosis of failed back surgery syndrome. The treating physician states on his report 08/06/2013, "Start compounded cream for radicular pain." However, the provider does not specify what this compounded cream is. Without the knowledge of what is contained in compounded cream, the request cannot be authorized. The MTUS Guidelines have specific recommendations regarding use of compounded creams. If one of the compounded creams is not recommended then entire compounded cream cannot be authorized. Therefore, it is essential that the specific contents of compounded cream be provided. As such, the recommendation is for denial.