MAXIMUS Federal Services

Case Number:	CM13-0044857		
Date Assigned:	12/27/2013	Date of Injury:	02/24/1997
Decision Date:	03/12/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	11/01/2013

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 and rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 67-year-old who reported an injury on 02/27/1997. The mechanism of injury was not provided for review. Patient's injury ultimately resulted in a multilevel fusion hardware removal. The patient's most recent clinical evaluation revealed severe back pain radiating into the left leg, limited range of motion secondary to pain with general deconditioning or sleep hygiene and an antalgic gait. Treatment to date included surgical intervention, medications and a psychological evaluation. The patient's diagnoses included chronic severe low back pain radiating into the lower extremities and epidural fibrosis versus arachnoiditis. The patient's treatment plan included peripheral neuromodulation stimulation implantation, motorized wheelchair, consultation for a pre stimulation trial, in intrathecal pump, an in home care for 12 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

A PNS (peripheral nerve stimulator) implant (pending psychiatric evaluation): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS) Section Page(s): 105.

Decision rationale: The requested PNS implant pending psych evaluation is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines recommends the implantation of a spinal cord stimulator for patients who have failed back surgery syndrome be supported by psychological evaluation failure to progress through at least six months of conservative treatment to include active therapy. The clinical documentation submitted for review does indicate that the patient has had a psychological evaluation; however, this was not submitted for review. Additionally, the most recent clinical documentation fails to include if the patient is actively participating in conservative treatments for pain control. The request for a PNS implant (pending psychiatric evaluation) is not medically necessary or appropriate.

A motorized wheelchair for difficulty ambulating: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMDs) Section Page(s): 99.

Decision rationale: The requested motorized wheelchair for difficulty ambulating is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines recommends power mobility devices for patients who have ambulation deficits that cannot be sufficiently resolved by lower levels of equipment. The clinical documentation submitted for review does not provide any evidence that the patient has failed to use lower levels of equipment to assist with ambulation. There is no documentation that the patient's deficits cannot be sufficiently resolved with a cane, walker, or optimally configured manual wheelchair. Therefore, a motorized wheelchair would not be indicated. The request for a motorized wheelchair for difficulty ambulating is not medically necessary or appropriate.

A consultation for a pre-stimulator trial: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS), Page(s): 105.

Decision rationale: The requested consult for Pre-Stim trail evaluation is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines recommends the implantation of a spinal cord stimulator for patients who have failed back surgery syndrome be supported by psychological evaluation failure to progress through at least six months of conservative treatment to include active therapy. The clinical documentation submitted for review does indicate that the patient has had a psychological evaluation; however, this was not submitted for review. Additionally, the most recent clinical documentation fails to include if the patient is actively participating in conservative treatments for pain control. The request for a consultation for a pre-stimulator trial evaluation is not medically necessary or appropriate.

IT (Intrathecal) pump therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Drug-Delivery Systems (IDDSs) Section Page(s): 52.

Decision rationale: Requested intrathecal pump therapy is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has failed back syndrome chronic severe pain. The Chronic Pain Medical Treatment Guidelines recommends the use of intrathecal pump therapy for patients who suffer from failed back syndrome who have failed to respond to conservative treatment and have a psychological evaluation to determine treatment success. The clinical documentation submitted for review does not provide any evidence that the patient has had any conservative therapy to include any active therapy the patient's recent treatment history. Although it is noted that the patient has undergone a psychological evaluation, this was not provided for review. The request for IT pump therapy is not medically necessary or appropriate.

Twelve in-home care visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Page(s): 51.

Decision rationale: The requested in home care x12 visits is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines recommends in home care for patients who are home bound on a part time or intermittent basis. The clinical documentation submitted for review does not indicate that the patient is home bound on a part time or intermittent basis. For the need for in home care is not established. The request for twelve in-home care visits is not medically necessary or appropriate.