

Case Number:	CM14-0015917		
Date Assigned:	06/04/2014	Date of Injury:	11/21/2000
Decision Date:	07/14/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/07/2014

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 Occupational Medicine, 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:

The patient is a 62-year-old female who has submitted a claim for failed back surgery, Syndrome Lumbar, and Radiculopathy Thoracic or Lumbosacral, associated with an industrial injury date of November 21, 2000. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of moderate to severe back pain radiating to the left ankle, calf, foot, and thigh. On physical examination, there was tenderness of the thoracic and lumbar spine. Extremity edema was absent. No sensorimotor deficits were reported. Gait and balance was intact. Mental status exam was unremarkable. An X-ray of the lower spine dated September 4, 2013 revealed mild dextroconvex thoracolumbar scoliosis, no evidence of vertebral subluxation, marked narrowing of the L5-S1 disc, and mild progressive lower lumbar facet spondylitic change. Treatment to date has included medications, TENS unit, orthotics, L4-5 discectomy, lumbar epidural steroid injections, and spinal cord stimulator trial. Utilization review from February 4, 2014 did not grant the request for percutaneous implantation of neurostimulator trial, SCS programming of generator, 16 implant neurostimulaor electrodes and removal at completion of trial, and a pre-op chest x-ray because the documentation provided did not contain a detailed physical examination identifying musculoskeletal deficits and a psychological evaluation providing psychological clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR TRIAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations, IDDS & SCS; Spinal Cord Stimulators (SCS) Page(s): 101, 105-107.

Decision rationale: According to the California MTUS Chronic Pain Medical Treatment Guidelines, spinal cord stimulators (SCS) are recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. Indications for stimulator implantation include failed back syndrome, complex regional pain syndrome/reflex sympathetic dystrophy, post-amputation pain, post-herpetic neuralgia, spinal cord injury dysesthesias, pain associated with multiple sclerosis, and peripheral vascular disease. In addition, the California MTUS Chronic Pain Medical Treatment Guidelines recommend psychological evaluation prior to SCS trial. In this case, a psychological clearance was provided prior to SCS trial. However, the medical records also showed that medications were able to provide functional benefits and the patient was able to perform her activities of daily living. There was no discussion regarding failure of other less invasive procedures for failed back surgery syndrome. Therefore, the request for Percutaneous Implantation of the Neurostimulator trial is not medically necessary.

SPINAL CORD STIMULATOR PROGRAMMING OF GENERATOR: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

16 IMPLANT NEUROSTIMULATOR ELECTRODES & REMOVAL AT COMPLETION OF TRIAL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

PRE-OP CHEST X-RAY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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