MAXIMUS Federal Services

Case Number:	CM14-0031677		
Date Assigned:	03/19/2014	Date of Injury:	02/01/2003
Decision Date:	07/29/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	03/12/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 is a 55 year old male patient with a 2/1/03 date of injury. The patient has attended a functional restoration program. The 2/26/14 progress note indicates that the patient had a flare up of low back pain 2 weeks ago. His pain is rated 7/10. He continues to have low back pain with radiation of pain into the left lower extremity to the foot. He denies any pian in the right leg. He also has pain around both knees. He is walking regularly for exercise. He is interested in a spinal cord stimulator and does not want to have any major spine surgery. MRI lumbar spine 11/27/07 reportedly demonstrated mild degenerative changes at L5-S1 with minimal central bulge, nomral central canal and lateral recesses, minimal bilateral intervertebral neural foraminal narrowing, L4-5 mild central bulge, moderate facet arthrosis and ligamentous hypertrophy, normal central canal and lateral recesses, mild to moderate right intervertebral neural foraminal narrowing, mild left intervertebral neural foraminal narrowing. Objectively, there is limited lumbar flexion, positive SLR on the right, left lower extremiet 4/5 strength, absent Achilles and patellar reflexes bialterally. Discussion states that the patient had benefit from lumbar epidural steroid injection in the past, but the last injection on 5/22/13 did not provide as much relief. He is interested in a SCS trial. The patient is also noted to have had a positive discogram at L4-5 and L5-S1 and a lumbar fusion could be another treatment option. The patient would like to avoid surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAIL SPINAL CORD STIMULATOR WITH [redacted] DORSAL COLUMN STIMULATOR TRIAL WITH TRIAL LEAD X 8 ELECTRONIC ANALYSIS OF PUMP, FLUOROSCOPIC GUIDANCE- LUMBAR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluation Page(s): 105-107.

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

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines & ODG criteria for SCS trial placement include: at least one previous back operation and patient is not a candidate for repeat surgery, symptoms are primarily lower extremity radicular pain; there has been limited response to non-interventional care (e.g. neuroleptic agents, analgesics, injections, physical therapy, etc.); psychological clearance indicates realistic expectations and clearance for the procedure; there is no current evidence of substance abuse issues; and that there are no contraindications to a trial. In addition, neurostimulation is generally considered to be ineffective in nociceptive pain. It seems that the patient may be a candidate for surgical intervention (2 level fusion). There is no psychological clearance for the trial. There is no clear documentation that all measures of interventional care have been tried and exhausted. California MTUS criteria for medical necessity have not been met. Therefore, the request was not medically necessary.

IV SEDATION- LUMBER SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluation Page(s): 105-107.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American Association of Neurological Surgeons.

Decision rationale: The American Associations of Neurological Surgeons states that during the second phase of the SCS implantation procedure, permanent electrode placement is performed in a surgical suite under a combination of local anesthetic and intravenous sedation. However, given that the SCS trial is not deemed medically necessary, the IV sedation lumbar spine is unnecessary. Therefore, the request was not medically necessary.

KETAMINE 5% CREAM 60GR # 1 WITH 3 REFILLS: Upheld

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

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

Decision rationale: California MTUS states that topical Ketamine is under study: Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. It is noted entirely clear that the patient has been refractory to all other primary and secondary treatment options. The request is not medically necessary.

CAPSAICIN 0.025% CREAM # 1 WITH 3 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines identify on page 28 that topical Capsaicin is only recommended as an option when there was failure to respond or intolerance to other treatments; with the 0.025% formulation indicated for osteoarthritis. This patient is noted to have lumbar radiculopathy, not osteoarthritis. The request is not medically necessary for this patient.