

Case Number:	CM14-0193902		
Date Assigned:	12/01/2014	Date of Injury:	03/09/2001
Decision Date:	01/14/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	11/19/2014

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 Orthopedic Surgery 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:

According to the records made available for review, this is a 73-year-old female with a 3/9/01 date of injury. At the time (9/11/14) of request for authorization for Spinal cord stimulator removal, there is documentation of subjective (worsening pain over bilateral buttock radiating to posterior and lateral aspect of bilateral thigh with numbness and tingling progressively increasing in severity) and objective (Gaenslen's test and Patrick Fabre tests positive, sacroiliac joint thrust severely positive, and better range of motion and functionality after sacroiliac joint injection) findings, current diagnoses (sacroiliitis of right sacroiliac joint), and treatment to date (spinal cord stimulator and sacroiliac joint injections). 9/11/14 medical report identifies a plan for removal spinal cord stimulator since it is not working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator removal: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.ncbi.nlm.nih.gov/pubmed/16961078> J Neurosurgeon Spine, 2006 Sep;5(3); 183-90; Rosenow JM1, Stanton-Hicks M, Rezai AR, Henderson JM; 1Department of Neurosurgery, Feinberg School of Medicine of Northwestern University, Chicago, Illinois 60611, USA. jrosenow@nmff.org.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS) Page(s): 105-107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Spinal Cord Stimulators (SCS), and on the Other Medical Treatment Guideline or Medical Evidence: [http://www.aans.org/PatientInformation/Conditions and Treatments/Spinal Cord Stimulation.aspx](http://www.aans.org/PatientInformation/ConditionsandTreatments/SpinalCordStimulation.aspx).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), primarily lower extremity pain, less invasive procedures have failed or are contraindicated, and a psychological evaluation prior to a trial, as criteria necessary to support the medical necessity of spinal cord stimulation in the management of failed back syndrome. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that SCS is recommended as a treatment option for adults with chronic neuropathic pain lasting at least 6 months despite appropriate conventional medical management, and who have had a successful trial of stimulation, as criteria necessary to support the medical necessity of permanent spinal cord stimulation. ODG identifies documentation of 50% pain relief and medication reduction or functional improvement after temporary trial, as criteria necessary to support the medical necessity of permanent spinal cord stimulation. Medical Treatment Guideline identifies documentation of device malfunction or displaced/damaged lead to support the medical necessity of a revision/re-implantation of a spinal cord stimulator. Within the medical information available for review, there is documentation of a diagnosis of sacroiliitis of right sacroiliac joint. In addition, given documentation of a rationale for removal of spinal cord stimulator since it is not working, there is documentation of device malfunction. Therefore, based on guidelines and a review of the evidence, the request for Spinal cord stimulator removal is medically necessary.