MAXIMUS Federal Services

Case Number:	CM14-0201750		
Date Assigned:	12/08/2014	Date of Injury:	02/03/2000
Decision Date:	02/10/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/02/2014

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 Medicine and is licensed to practice in 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 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 51 year old female who was injured on 2/3/2000. The diagnoses are failed back syndrome, CRPS / neuropathic pain of feet and back pain. There are associated diagnoses of anxiety, insomnia and depression.There is a history of use of intraspinal drug delivery system as well as spinal cord stimulator. The provider recommended replacement of the end of life spinal cord stimulator with an MRI compactible system.On 2/12/2014, the patient complained of severe pain and was prescribed oral Dilaudid medications in addition to the intrathecal opioids.The oral medications listed are Venlafaxine, gabapentin, Topamax and Robaxin. It is unclear which medications are current as many were noted to be partially or non certified.On 8/29/2014, [redacted] noted a neurological examination that did not show any reflex, sensory or motor deficits. On 11/20/2014, there was subjective complaint of knee and back pain.The pain score was noted to be 6-9/10 on a scale of 0 to 10. The hand written clinic notes are not legible. A Utilization Review determination was rendered on 11/20/2014 recommending non certification for generator replacement x 2 (percutaneous electrode), generator replacement x1 (spinal pulse generator/receiver), generator x1 (rechargeable implantable generator), leads x2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Generator replacement x2 (63650- Percutaneous implantation of neurostimulator electrode array, epidural): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter. Low and Upper Back.

Decision rationale: The CA MTUS did not address the use of spinal cord stimulator for the treatment of chronic low back pain. The ODG guidelines recommend that spinal cord stimulator can be utilized for the treatment of intractable severe pain from failed back syndrome that did not respond to conservative treatments with medications and PT. It is recommended that the patient should undergo psychological clearance to diagnose psychosomatic causes of the failure of conservative management. The records indicate that the patient was diagnosed with insomnia, stress, anxiety and depression. There is no documentation of current psychiatric treatment or psychological clearance. The records indicate that the patient was also utilizing intrathecal pump and oral opioid medications and sedatives when the spinal cord stimulator was functioning. This indicated that neither the spinal cord stimulator nor the pain pump was efficacious in decreasing the oral medications utilization per guidelines indications. There was no documented functional improvement. The pain history did not indicate that replacement of with a new spinal cord stimulator will result in the guideline recommended treatment outcome. The criteria for the generator replacement X2 63650 (percutaneous) was not met.

Generator replacement x 1 (63685- Insertion or replacement of spinal neurotimulator pulse generator or receiver, direct or inductive couping): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Upper Back.

Decision rationale: The CA MTUS did not address the use of spinal cord stimulator for the treatment of chronic low back pain. The ODG guidelines recommend that spinal cord stimulator can be utilized for the treatment of intractable severe pain from failed back syndrome that did not respond to conservative treatments with medications and PT. It is recommended that the patient should undergo psychological clearance to diagnose psychosomatic causes of the failure of conservative management. The records indicate that the patient was diagnosed with insomnia, stress, anxiety and depression. There is no documentation of current psychiatric treatment or psychological clearance. The records indicate that the patient was also utilizing intrathecal pump and oral opioid medications and sedatives when the spinal cord stimulator was functioning. This indicated that neither the spinal cord stimulator nor the pain pump was efficacious in decreasing the oral medications utilization per guidelines indications. There was no documented functional improvement. The pain history did not indicate that replacement of with a new spinal cord stimulator will result in the guideline recommended treatment outcome. The criteria for the

generator replacement X 1 63685 (insertion /replacement of spinal neurostimulator pulse generator /receiver, direct / inductive) was not met.

Generator x1 (L8687- Implantable neurotimulator pulse generator, dual array, rechargeable, includes extension): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter Low and Upper Back.

Decision rationale: The CA MTUS did not address the use of spinal cord stimulator for the treatment of chronic low back pain. The ODG guidelines recommend that spinal cord stimulator can be utilized for the treatment of intractable severe pain from failed back syndrome that did not respond to conservative treatments with medications and PT. It is recommended that the patient should undergo psychological clearance to diagnose psychosomatic causes of the failure of conservative management. The records indicate that the patient was diagnosed with insomnia, stress, anxiety and depression. There is no documentation of current psychiatric treatment or psychological clearance. The records indicate that the patient was also utilizing intrathecal pump and oral opioid medications and sedatives when the spinal cord stimulator was functioning. This indicated that neither the spinal cord stimulator nor the pain pump was efficacious in decreasing the oral medications utilization per guidelines indications. There was no documented functional improvement. The pain history did not indicate that replacement of with a new spinal cord stimulator will result in the guideline recommended treatment outcome. The criteria for the generator X1 L8687 (implantable neurostimulator generator, dual array, rechargeable, includes extensions) was not met.

Leads x2 (L8680 - Implantable neurostimulator eletrode): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter. Low and Upper Back Pain.

Decision rationale: The CA MTUS did not address the use of spinal cord stimulator for the treatment of chronic low back pain. The ODG guidelines recommend that spinal cord stimulator can be utilized for the treatment of intractable severe pain from failed back syndrome that did not respond to conservative treatments with medications and PT. It is recommended that the patient should undergo psychological clearance to diagnose psychosomatic causes of the failure of conservative management. The records indicate that the patient was diagnosed with insomnia, stress, anxiety and depression. There is no documentation of current psychiatric treatment or psychological clearance. The records indicate that the patient was also utilizing intrathecal pump

and oral opioid medications and sedatives when the spinal cord stimulator was functioning. This indicated that neither the spinal cord stimulator nor the pain pump was efficacious in decreasing the oral medications utilization per guidelines indications. There was no documented functional improvement. The pain history did not indicate that replacement of with a new spinal cord stimulator will result in the guideline recommended treatment outcome. The criteria for the Leads X 2 L8680 (implantable neurostimulator electrode) was not met.