MAXIMUS Federal Services

Case Number:	CM15-0017900		
Date Assigned:	02/05/2015	Date of Injury:	12/21/2005
Decision Date:	04/06/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	01/30/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York, New Hampshire, Washington
Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 64 year old male who sustained an industrial injury on 12/21/2005. Diagnoses include failed back surgery, intractable neuropathic pain syndrome with failed exhaustive conservative care, status post peripheral nerve field stimulator implant failed, and lumbar spondylosis. Treatment to date has included laminectomy, physical therapy, and medications. A physician progress note dated 01/13/2015 documents the injured worker complains of intractable low back and buttock pain. There is tenderness in the lumbosacral musculature and over the lumbar spinous processes. Range of motion revealed flexion was performed with complaints of end range pain. Lumbar facet compression test caused him to report concordant secondary pain in the low back and referred into the buttocks and thighs. Gait revealed antalgic won the left side with some stiffness. The peripheral nerve field stimulator has failed completely. Treatment requested is for Spinal cord stimulator implant with paddle via the translaminar approach with new IPG pouch to be completed by spine surgeon, Medical clearance by internal medicine MD, and Psychiatric evaluation and clearance for spinal cord stimulator. On 01/26/2015 Utilization Review non-certified the request for Spinal cord stimulator implant with paddle via the translaminar approach with new IPG pouch to be completed by spine surgeon and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines, and Official Disability Guidelines. On 01/26/2015 Utilization Review non-certified the request for Medical clearance by internal medicine MD, and cited was Official Disability Guidelines. On 01/26/2015 Utilization Review non-certified the request for Psychiatric evaluation and clearance for spinal cord stimulator, and cited was California Medical

Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines, and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator implant with paddle via the translaminar approach with new IPG pouch to be completed by spine surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations and Spinal cord stimulators (SCS) Page(s): 101 and 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines spinal cord stimulator Page(s): 121,Postsurgical Treatment Guidelines.

Decision rationale: The records that the patient has chronic low back pain. There is no documentation of patient extremity pain complaints. SCS device is indicated for pain in extremities not chronic axial back pain. SCS device for axial back pain only symptoms has low success rates and is not supported by guidelines (ODG). SCS device not medically needed.

Medical clearance by internal medicine MD: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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.

Psychiatric eval and clearance for SCS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations, IDDS & SCS and Spinal cord stimulators (SCS) Page(s): 101 and 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

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.