

Case Number:	CM15-0200876		
Date Assigned:	10/15/2015	Date of Injury:	05/02/2001
Decision Date:	11/30/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/13/2015

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 Jersey, New York
 Certification(s)/Specialty: Family Practice

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 66 year old female who sustained an industrial injury on 5-2-01. Diagnoses are noted as back pain-lumbago, radiculopathy-radiculitis, and post-laminectomy lumbar region. Subjective complaints (9-16-15) include axial low back pain rated 10 out of 10 with a medication follow up: reported 90% relief during the last 3 months. It is noted (9-16-15) that a lumbar epidural steroid injection is scheduled. Objective findings (8-30-15) include decreased lumbar range of motion, moderate spasm and pain with palpation throughout the lumbar spine, positive straight leg raise bilaterally at 30 degrees, decreased sensation to light touch and pinprick in L5 and S1, and motor diminished 3 out of 5 in plantar and dorsiflexion. Previous treatment includes X-rays, MRI, back surgery, rehabilitation program (physical therapy, pain medication, massage, transcutaneous electrical nerve stimulation, heat applications without reported major relief). The requested treatment of 2 implant of neuroelectrodes, 1 neurostimulator analysis, 1 implantable neurostimulator electrode was non-certified on 9-25-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 implant of neuroelectrodes: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

Decision rationale: The request is considered medically necessary at this time. The patient has been on multiple medications without relief of pain. He failed back surgery. Previous treatment includes rehabilitation program (physical therapy, pain medication, massage, transcutaneous electrical nerve stimulation, heat applications without reported major relief). The patient has failed most conservative therapy. The patient also had a psychological evaluation which stated he was of fair risk psychologically and there was no reason to delay the procedure. Therefore, the request is considered medically necessary.

One (1) neurostimulator analysis: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

Decision rationale: The request is considered medically necessary at this time. The patient has been on multiple medications without relief of pain. He failed back surgery. Previous treatment includes rehabilitation program (physical therapy, pain medication, massage, transcutaneous electrical nerve stimulation, heat applications without reported major relief). The patient has failed most conservative therapy. The patient also had a psychological evaluation which stated he was of fair risk psychologically and there was no reason to delay the procedure. Therefore, the request is considered medically necessary.

One (1) implantable neurostimulator electrode: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

Decision rationale: The request is considered medically necessary at this time. The patient has been on multiple medications without relief of pain. He failed back surgery. Previous treatment includes rehabilitation program (physical therapy, pain medication, massage, transcutaneous electrical nerve stimulation, heat applications without reported major relief). The patient has failed most conservative therapy. The patient also had a psychological evaluation, which stated he was of fair risk psychologically and there was no reason to delay the procedure. Therefore, the request is considered medically necessary.