

<b>Case Number:</b>	CM14-0121926		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	05/05/1994
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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 Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 60-year-old female who reported an injury on 05/05/1994. The mechanism of injury was not provided. On 08/25/2014, the injured worker presented with persistent back pain. The diagnoses were chronic low back pain with multilevel fusion surgery, and status post spinal cord stimulator placement in 02/2014. The provider recommended a spinal cord stimulator replacment, wean the injured worker down on her medications and a followup appointment. The Request for Authorization Form was not included in the medical documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Spinal Cord Stimulator Replacement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): SPECIAL CONSIDERATIONS& SURGICALPROCEDURES. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES- TREATMENT WORKERS' COMPENSATIONSPINAL CORD STIMULATION

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator Page(s): 105-106.

**Decision rationale:** The California MTUS Guidelines state that implantable spinal cord stimulators are rarely used and should be reserved for injured workers with low back pain for more than 6 months' duration who has not responded to standard nonoperative or operative interventions. Indications the use of spinal cord stimulators include low back syndrome, complex regional pain syndrome, postamputation pain, postherpetic neuralgia, spinal cord injury with dysesthesias with and pain associated with multiple sclerosis, as well as peripheral vascular disease. The guidelines recommend spinal cord stimulators for injured workers who have undergone at least 1 previous back operation and who are not a candidate for repeat surgery with symptoms of primary lower extremity radicular pain, a psychological clearance, no current evidence of symptoms of overuse issues and no contraindications to a trial. Permanent placement requires evidence of 50% pain relief with medication reduction or functional improvement after the temporary trial period. The documentation presented for review lacked evidence of failed back surgery and the failure of the injured worker to respond to conservative treatment. There is lack of documentation of the injured worker's prior use of a spinal cord stimulator. As a spinal cord stimulator will not be indicated, a replacement will not be warranted. As such, medical necessity has not been established.

**Follow-Up Appointment (with [REDACTED]):** 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) Low Back, Office Visit.

**Decision rationale:** The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of an injured worker. The need for a clinic office visit with a health care provider is individualized, based upon a review of the injured worker's concerns, signs and symptoms, clinical stability and reasonable physician judgment. As the injured worker's conditions are extremely varied, number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review of an assessment, being ever mindful that the best injured worker outcomes are achieved with the eventual patient independence from the health care system through self care as soon as clinically feasible. The provider's rationale for a followup appointment was not provided. Additionally, the lack of documentation on how a followup appointment would allow the provider to evolve any treatment plan or goals for the injured worker. As such, medical necessity has not been established.