

<b>Case Number:</b>	CM15-0014843		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	07/26/2012
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 30-year-old male who reported an injury on 07/26/2012. The mechanism of injury involved heavy lifting. The current diagnosis is lumbar spondylolisthesis status post lumbar fusion/failed back syndrome. According to a utilization review treatment appeal letter dated 01/07/2015, the injured worker was pending a spinal cord stimulator trial. The injured worker reported intractable low back pain radiating into the bilateral lower extremities. The injured worker also noted numbness and tingling in the bilateral lower extremities. Upon examination, there was normal cervical lordosis and thoracic kyphosis, flattening of lumbar lordosis, a well healed surgical scar over the lumbar spine, flexion to 25 degrees, extension to 0 degrees, lateral tilt limited by 75%, 2+ deep tendon reflexes, nonfocal sensory examination in the lower extremities, difficulty assessing motor examination secondary to pain, and positive straight leg raising bilaterally. Treatment recommendations included a psychological screening prior to the spinal cord stimulator trial. The provider indicated the injured worker has tried and failed conservative treatment including medication, physical therapy, TENS therapy, and a lumbar epidural steroid injection. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trial Spinal Cord Stimulator w/ Medtronic: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105 &107.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators), Spinal Cord Stimulators (SCS) Page(s): 101, 105-106.

**Decision rationale:** The California MTUS Guidelines state spinal cord stimulators are recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. In this case, it was noted that the injured worker maintains a diagnosis of failed back syndrome. However, the California MTUS Guidelines recommend a psychological screening prior to a spinal cord stimulator trial. In the absence of psychological clearance, the request for a spinal cord stimulator trial cannot be determined as medically appropriate at this time. As such, the request is not medically necessary.

**Dorsal Column Stimulator Trial Lead: Upheld**

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

**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.

**Electronic Analysis of Pump: Upheld**

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

**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.

**Fluoroscopic Guidance IV Sedation: Upheld**

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

**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.

