

Case Number:	CM15-0078480		
Date Assigned:	04/30/2015	Date of Injury:	06/08/2004
Decision Date:	05/29/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/24/2015

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
Certification(s)/Specialty: Neurological 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 63 year old male with an industrial injury dated 6/08/2004. The injured worker's diagnoses include right sacroiliac (SI) joint dysfunction, status post stimulator implant, failed back surgery syndrome, lumbar radiculopathy, lumbar facet arthropathy and depression. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 3/25/2015, the injured worker reported right lower back pain and right lower extremity pain. Objective findings revealed severe tenderness over lower lumbar area and sacroiliac (SI), positive Fabere test, positive straight leg raises on the right and limited lumbar range of motion due to pain. The treating physician prescribed services for bilateral superior cluneal spinal cord stimulator trial and associated surgical service: leads, remove leads, reprogram stim, anesthesia, lumbar x-ray, leads x2, pre-operative testing and Percocet now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Lumbar x-rays: 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.

Associated surgical service: Leads: 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.

Associated surgical service: Remove leads: 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.

Associated surgical service: Reprogram stim: 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.

Associated surgical service: Anesthesia: 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.

Bilateral superior cluneal spinal cord stimulator trial: Upheld

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

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 chapter- spinal cord stimulation (SCS); Galvanic stimulation, H-wave stimulation; Inferential current stimulation; pulsed stimulation, pulsed radiofrequency stimulation.

Decision rationale: The ODG guidelines note that when spinal cord stimulation fails, then reoperation is unlikely to succeed. The ODG guidelines note Galvanic stimulation, H-wave stimulation, inferential current stimulation, pulsed stimulation, and pulsed radiofrequency stimulation is not recommended. Documentation does not include evidence that stimulation of the cluneal nerves would do anything to help the patient's back pain which the documentation shows is the primary complaint. The requested treatment: Bilateral superior cluneal spinal cord stimulator trial is NOT Medically necessary and appropriate.

Associated surgical service: Leads x 2: 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.

Pre-op testing: 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.

Percocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74.

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.