

<b>Case Number:</b>	CM14-0008603		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	12/20/2001
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	01/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/22/2014

### 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, has a subspecialty in Pain Management, and is licensed to practice in California. 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:

This is a male patient with the date of injury of December 20, 2001. A utilization review determination dated January 6, 2014 recommends non-certification of a sacral neural stimulator. The previous reviewing physician recommended non-certification of sacral neural stimulator due to lack of documentation of urodynamic studies, symptoms, objective findings, prior treatment, and the rationale for the stimulator. A Progress Report dated December 17, 2013 identifies Subjective findings of chronic low back pain, with radicular symptoms to his lower extremities. The patient also continues to note erectile dysfunction and some urinary leakage incontinence. Objective findings identify tenderness to palpation throughout the lumbar spine, with tenderness noted in the left lumbar paraspinal region extending into the left buttock. Sensation to light touch was slightly reduced along the anterolateral aspect of the left thigh. Assessment identifies lumbar DDD, status post lumbar laminectomy, L4-5 anterior and posterior fusion, follow by removal of instrumentation; chronic low back pain; lumbosacral radiculopathy; erectile dysfunction and urinary leakage incontinence; pain-related insomnia; pain-related depression; obesity; and past medical history of diabetes, hypertension, GERD (gastroesophageal reflux disease), and obstructive sleep apnea. Plan identifies neural sacral stimulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SACRAL NERVE STIMULATOR:** 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 Other Medical Treatment Guideline or Medical Evidence: <http://emedicine.medscape.com/article/2036909-overview#aw2aab6b2b2>

**Decision rationale:** Regarding the request for sacral nerve stimulator, California MTUS and ODG do not address the issue. Sacral nerve stimulation is indicated for the treatment of urinary retention and symptoms of overactive bladder, including urinary incontinence and significant symptoms of urinary frequency, alone or in combination, in patients in whom more conservative therapies have failed or were not tolerated. Within the medical information available for review, the patient is noted to have urinary leakage incontinence. However, there is no mention that more conservative therapies have been tried and failed or were not tolerated. The request for a sacral nerve stimulator is not medically necessary or appropriate.