

<b>Case Number:</b>	CM14-0102139		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	08/13/2001
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	06/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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 is licensed to practice in Illinois. 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 65-year-old female who reported an injury on 08/13/2001 due to an unknown mechanism. Diagnoses were possible left lumbar screw back out, left L2 radiculopathy, L1-2 degenerative disc disease with kyphosis and instability, status post L3-5 anterior fusion, status post previous L2-S1 fusion, L4-5 spondylolisthesis, bilateral sacroiliac joint dysfunction, right greater trochanter bursitis, L4 burst fracture, and status post L4 corpectomy. Past treatments were not reported. Diagnostic studies were CT of the pelvic and MRI of the lumbar spine. The MRI revealed increased disc herniation at the L3-4, myelogram, plus L4-5 lesion. The injured worker has had multiple spinal surgeries. Surgical history included status post laminectomy and fusion at the L3-4 and L5-S1, 3 level fusion lumbar spine, bilateral S1 joint fusion, and revision surgery. The injured worker had a physical examination on 04/29/2014 with complaints of low back and leg pain. She ambulated with a walker. The injured worker reported about 6 hours of disturbed sleep. The injured worker's daughter accompanied her at this office visit and stated that she does not agree with the high level of opioids. Average pain reported since last visit was an 8/10 to 9/10, and functional level since last visit was reported at 7/10 to 8/10. The injured worker denied any side effects from the medications. Examination revealed pain traveled to buttocks down to toes with neuropathic pain. There was tenderness to palpation over the right and left sacroiliac joints. Medications were Actiq, Celebrex, Cymbalta, Lazanda, Lyrica, Methadone, Nucynta, Prednisone, Tizanidine, Fiorinol, and Fentanyl patches. Treatment plan was to obtain a request for a CT of the lumbar spine and to get a psych evaluation done for an IT pump or an SCS trial. The rationale and Request for Authorization were not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **CT Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Computed Tomography.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The request for CT lumbar spine per the California ACOEM recommends criteria of unique symptoms and unique signs to be found on an objective physical examination. For spinal stenosis, there are unique signs such as nonspecific low back and leg pain, or leg pain worse with activity (pseudoclaudication). Unique signs to look for are straight leg raising test was negative, or symptoms reproduced by patients sustained hyperextension of spine while standing. A straight leg-raising test may be positive if performed immediately after patient has exercised. Unequivocal objective findings that identify specific nerve compromise on a neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false positive findings, such as disc bulges, that are not the source of painful symptoms and do not warrant surgery. Physiologic evidence indicates tissue insult or nerve impairment. The practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging) for neural or other soft tissue, or computed tomography for bony structures. X-ray revealed a new lesion at the L4-5. The examination did not reveal any unique symptoms or unique signs that the medical guidelines have outlined. The request for CT lumbar spine is not medically necessary.

### **IT Pump Trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator, Indications for Stimulator Implantation Page(s): 105,107.

**Decision rationale:** The request for IT pump trial per the California Medical Treatment Utilization Schedule states the indicates for stimulator implantation is documentation of failed back syndrome (persistent pain in patients who have undergone at least 1 previous back operation), more helpful for lower extremity than low back pain, although both stand to benefit, 40 to 60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or

lumbar. For complex regional pain syndrome (CRPS)/reflex sympathetic dystrophy (RSD), 70% to 90% success rate, at 14 to 41 months after surgery. For the treatment of amputation pain (phantom limb pain), there is a 68% success rate. For the treatment of postherpetic neuralgia, there is a 90% success rate. Spinal cord injuries (pain in lower extremities associated with spinal cord injury). The stimulator implantation can be used for pain associated with multiple sclerosis. It is also indicated for the use of peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. The guidelines also state for a spinal cord stimulator, psychological evaluation must be obtained. Due to the fact that there was no psychological evaluation, this request is not medically necessary.