

<b>Case Number:</b>	CM14-0197962		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	07/05/2008
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Orthopedic Surgery, and is licensed to practice in Georgia. 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 47-year-old male who reported an injury on 07/15/2008. The mechanism of injury was not submitted for review. The injured worker's diagnoses are status post posterior spinal fusion, C5-6, for nonunion, anterior cervical fusion, C5-6, and history of Parkinson's disease. Past medical treatment consists of surgery, physical therapy, and medication therapy. Medications consist of omeprazole, cyclobenzaprine, and hydrocodone/acetaminophen. Diagnostics consist of x-rays of the cervical spine which showed good progression of the fusion. On 11/21/2014, the injured worker complained of cervical spine pain. He also mentioned right upper extremity pain; however, he mentioned it improved. Physical examination revealed limited range of motion. Neurologic exam of the upper extremities was intact, other than the tremor in the right hand. Medical treatment plan is for the injured worker to undergo dorsal column stimulator implantation and trial. The provider feels the spinal cord stimulator is necessary, as the injured worker has failed all reasonable therapies. The Request for Authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dorsal column stimulator implantation and trial:** Upheld

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

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

**Decision rationale:** The request for dorsal column stimulator implantation and trial is not medically necessary. The California MTUS Guidelines' indications for stimulator implantation are as follows: Signed failed back syndrome (persistent pain in patients who have undergone at least 1 previous back operation, complex regional pain syndrome, post amputation pain, postherpetic neuralgia, spinal cord injury dysesthesias, pain associated with multiple sclerosis and/or peripheral vascular disease. Guidelines go on to state that spinal cord stimulators are recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. Progress note dated 11/21/2014 indicated that the patient had limited range of motion. Neurologic exam of the upper extremities was intact. Additionally, it was indicated on that progress report that x-rays of the cervical spine revealed good progression of the fusion. Furthermore, there was no indication of the injured worker having a diagnosis congruent with the above guideline. Given the above, the injured worker is not within MTUS recommended guideline criteria. As such, the request is not medically necessary.