

<b>Case Number:</b>	CM14-0198844		
<b>Date Assigned:</b>	12/09/2014	<b>Date of Injury:</b>	11/07/2006
<b>Decision Date:</b>	02/23/2015	<b>UR Denial Date:</b>	10/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2014

### 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. 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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 patient is a 40-year-old male presenting with a work-related injury on November 7, 2015. According to the medical records the patient has a history of long-term opiates usage. The patient received a dorsal column stimulator trial on August 7, 2014. And tolerated the prior simulation unit very well. The patient reported however that it felt like the trial unit was not placed in the right spot. Following psychological evaluation, the patient was diagnosed with major depression partial remission dysthymia, pain disorder associated with medical and psychological factors, opiate dependence, personality disorder mild, passive independent features. It was recommended the patient 1010 to 12 psychotherapy sessions is that the pain. MRI of the thoracic spine without contrast complete on August 9, 2012 revealed minimal degenerative changes in the thoracic spine with some mild disc bulging at T 11 - 212. MRI of the lumbar spine complete on August 9, 2012 revealed mild degenerative disc and joint disease most prominent at L1 - L2, L4 - L5, and L5 - S1; there is also some mild disc bulging at L1 - L2 and L2 - L4. On August 27, 2014 the physical exam revealed right knee brace and cane for assistance, tenderness of the lumbar spine, decreased range of motion in bilateral paraspinal spasm noted, pain with extension and flexion, tenderness to palpation over the bilateral facet sacroiliac joint, decreased strength and reflexes at the patient bilateral extremities. A request was made for retrieval of spinal cord stimulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Retrial of Spinal Cord Stimulator: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator (SCS). Decision based on Non-MTUS Citation ODG, Spinal Cord Stimulator (SCS)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** Retrial of a spinal cord stimulator is not medically necessary. Per Ca MTUS spinal cord stimulator recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain. Indications for stimulator implantation: Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), more helpful for lower extremity than low back pain, although both stand to benefit, 40-60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered to be ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar. Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70- 90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis.), Post amputation pain (phantom limb pain), 68% success rate, Post herpetic neuralgia, 90% success rate Spinal cord injury dysesthesias (pain in lower extremities associated with spinal cord injury) Pain associated with multiple sclerosis, 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. (Flotte, 2004). Additionally, the guidelines indicate that the use of a spinal cord stimulator is a last resort when all other conservative attempts to control the patient's pain have failed, (for example, various medications including neuroleptics for neuropathic pain, injections, physical therapy.) In the medical records reviewed there is lack of documentation that the patient has failed adequate physical therapy. There is also lack of documentation of the type of therapy performed or the outcome; therefore the request for a spinal cord stimulator trial is not medically necessary and appropriate.