

<b>Case Number:</b>	CM14-0201909		
<b>Date Assigned:</b>	12/12/2014	<b>Date of Injury:</b>	03/09/2001
<b>Decision Date:</b>	01/28/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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 patient is a 41-year-old female presenting with a work-related injury on March 9, 2001. The patient is status post L2 - L3, L3 - L4, L4 - L5 and L5 - S1 posterior lumbar interbody fusion on December 6, 2007. The patient had removal of two clinical screws on June 2008. The patient then had removal of fusion hardware on September 21, 2009. On October 17, 2011 the patient underwent five or so later implant which provided 50 to 70% pain relief. On September 29, 2003 electrodiagnostic studies were within normal limits. On April 1, 2004 x-rays of the lumbar spine demonstrated in anterior wedge deformity of L1 and L2 with degenerative disc disease at L1 - L2 and L2 - L3. MRI of the cervical spine on March 25, 2010 demonstrated a grade 1 anterolisthesis at C4 and C5; some abutment in the exiting left cervical nerve roots; mild degree stenosis throughout the rest of the cervical spine. Nuclear medicine bone scan on April 29, 2010 demonstrated increase uptake in the mid thoracic and lumbar spine region consistent with previous surgery and fracture with an interval slight increase in compression fracture deformity at L1. CT myelogram in March 2011 demonstrated a classified deformity at about 35 at the thoracolumbar junction questionable non-- union at L4 - L5; there were scruples distally at T 12. X-ray and January 2014 documented epidural lead at the T 11 arbitral body when it should be at T7 - T8. Patient has tried physical therapy which was ongoing according to the medical records. Patient also reported ongoing stretching exercises at home. Patient received sacroiliac joint injection and reported 50% improvement. On October 28, 2014 the patient had trigger point injections which provided relief greater than 50% increase range of motion. On October 28, 2014 the physical exam was significant for tenderness to palpation over the posterior director lumbar spine bilaterally with increased muscle rigidity; there was significant body deformity; decreased range of motion with flexion and extension; straight leg raise is positive bilaterally to about 60 which cause radicular pain; reflexes were on fourth in the patella and absent in Achilles

bilaterally; the implantable generator site was well-healed; he was tender to palpation over the implantable generator site. The patient's medications include OxyContin and Neurontin. Patient was diagnosed with chronic low back pain. The authorized provider requested authorization for spinal cord stimulator that would entail replacing 4 leads.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Spinal cord stimulator with [REDACTED] IPG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 107.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Complex Regional Pain Syndrome Page(s): 32.

**Decision rationale:** Spinal cord stimulator with [REDACTED] IPG. 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 the patient reported about 50-70% relief with the spinal cord stimulator; however, there is lack of documentation to corroborate the patient's reports. There was no documentation of weaning of medications during the time that the spinal cord stimulator was operating. The patient was on Oxycontin and Neurontin. Additionally, there was lack of documentation of improved activity while the previous spinal cord stimulator was functioning properly; therefore the request for a spinal cord stimulator is not medically necessary and appropriate.