

<b>Case Number:</b>	CM15-0105239		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	02/11/2010
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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: Illinois, California, Texas

Certification(s)/Specialty: Orthopedic Surgery

### 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 52-year-old male who sustained an industrial injury on 2/11/10. Injury occurred while he was lifting a furnace with a dolly. The 3/5/12 electrodiagnostic study evidence mild right L5 and/or S1 radiculopathy and probable left L5 or S1 radiculopathy. The 1/14/13 lumbar CT myelogram impression documented a 4 mm diffuse disc osteophyte complex at L3/4 which encroached onto the foramina. There was moderate left and moderate to severe right neuroforaminal stenosis with normal central canal caliber. At L4/5, there was a 5 mm diffuse disc osteophyte complex which encroached onto the foramina. There was moderate central canal and lateral recess stenosis and moderate to severe foraminal stenosis. The 1/14/13 lumbar x-rays with flexion/extension viewed documented moderate degenerative disc disease throughout the lumbar spine with no evidence of dynamic instability. Records indicated that the injured worker was being followed for regular psychotherapy and that he had a psychiatric evaluation which cleared him for a spinal cord stimulator trial on 11/13/14. The 5/4/15 treating physician report cited constant low back pain radiating to the left lower extremity that averaged 6/10. Pain was worse with bending, movement and prolonged sitting. Pain was improved by applying cold, lying flat and resting. He reported difficulty staying asleep due to pain, feeling blue all the time, and frustration due to pain and muscle cramps. Current medications included Vicoprofen and Ambien. He reported Vicoprofen was much more effective at 2 tablets for temporary pain relief. Medications provided improved functionality 50-60% and pain by greater than 50%. He was continuing to see the psychologist. Physical exam documented antalgic gait, numbness over the back and posterior left knee, referred pain over the right anterior and posterior thigh, and severe

pain over the back and right groin. The diagnosis included degenerative lumbar/lumbosacral intervertebral disc, lumbago, and chronic pain due to trauma. The treating physician discussed various recommendations for a spinal cord stimulator trial. Authorization was requested for spinal cord stimulator trial for the lumbar spine. The 5/15/15 utilization review non-certified the request for spinal cord stimulator as there was no documentation of progressive deficits or that the injured worker had failed less invasive procedures or was contraindicated.

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

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

#### **Spinal cord stimulator trial for Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-92, 106.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

**Decision rationale:** The California MTUS recommend the use of spinal cord stimulator only for selected patients in cases when less invasive procedures have failed or are contraindicated. Indications included failed back syndrome, defined as persistent pain in patients who have undergone at least one previous back surgery, and complex regional pain syndrome. Consideration of permanent implantation requires a successful temporary trial, preceded by psychological clearance. Guideline criteria have not been met. This injured worker does not meet the diagnostic indications for spinal cord stimulator use. He has not undergone back surgery and has not been diagnosed with complex regional pain syndrome. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Current records indicate that medication management is providing 50-60% overall improvement. Therefore, this request is not medically necessary.