

Case Number:	CM15-0131835		
Date Assigned:	07/20/2015	Date of Injury:	05/04/2005
Decision Date:	08/14/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/08/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 54-year-old female, who sustained an industrial injury on May 4, 2005. Treatment to date has included medications, spinal cord stimulator trial, injections, heat/ice therapy, diagnostic imaging and physical therapy. Currently, the injured worker complains of low back pain and neck pain. She describes her low back pain as moderate-to-severe and she reports radiation of pain to the bilateral lower extremities. She describes the pain as an ache, burning, numbness, shooting and stabbing. Her symptoms are aggravated by bending, by daily activities, by lifting, by rolling over in bed, by standing and by walking. Head, ice, injections, physical therapy and medications relieve her symptoms. On physical examination, the injured worker exhibits a normal gait and has normal muscle tone of the lower extremities. She exhibits tenderness to palpation over the lumbar spine and the cervical spine. Her cervical and lumbar range of motion elicits pain. The diagnoses associated with the request include myalgia and myositis, muscle spasms, radiculopathy of the thoracic and lumbar spine, herniated nucleus pulposus of the lumbar spine and failed back surgery. The treatment plan includes spinal cord stimulator lead placement trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator (SCS) lead placement trial: Upheld

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

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

Decision rationale: According to MTUS guidelines, 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. (Mailis- Gagnon-Cochrane, 2004) (BlueCross BlueShield, 2004) See indications list below. 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) There is no evidence of failed previous surgery, radiculopathy or true neuropathic pain. There is no documentation of the efficacy of the spinal cord stimulator trial. Therefore, the request for Spinal cord stimulator (SCS) lead placement trial is not medically necessary.