

Case Number:	CM15-0165953		
Date Assigned:	09/03/2015	Date of Injury:	04/13/1993
Decision Date:	10/06/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	08/24/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 57-year-old female, who sustained an industrial injury on April 13, 1993. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having cervical disc displacement, fibromyalgia, cervical radiculitis, degeneration of the cervical intervertebral disc, post laminectomy syndrome of the cervical region, and headache. Treatment and diagnostic studies to date has included physical therapy, cervical epidural steroid injections, and medication regimen. In a progress note dated July 21, 2015 the treating physician reports complaints of a heavy, pressure pain to the neck that radiates to the lower spine and to the bilateral upper extremities along with frontal headaches, Examination reveals tenderness to the left trapezius with axial compression, decreased range of motion to the cervical spine, and decreased sensation to the upper extremity over the cervical five and cervical six dermatomes. The injured worker's pain level as rated a 7 out of 10. The treating physician noted greater than 50 to 60% relief in pain along with a reduction in daily headaches after the cervical epidural steroid injections performed on January 13, 2013. The treating physician requested psychological clearance for placement of a spinal cord stimulator along with a request for a spinal cord stimulator trial noting that the injured worker has chronic neck pain with headaches secondary to failed back syndrome of the cervical spine and is requesting a percutaneous spinal cord stimulator trial to achieve relief of pain and to start weaning the injured worker off of her medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychological clearance: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SCS Page(s): 106-107.

Decision rationale: 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) The patient does qualify for a SCS trial once cleared psychologically. So therefore, the need for clearance is medically necessary.

Spinal cord stimulator trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS); Indications for stimulator implantation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SCS Page(s): 107.

Decision rationale: 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) The patient should first be psychologically cleared for this procedure /treatment and therefore the request is not certified.