

Case Number:	CM15-0183670		
Date Assigned:	09/24/2015	Date of Injury:	04/10/2002
Decision Date:	11/09/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	09/18/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 60 year old male, who sustained an industrial injury on 4-10-2002. The injured worker was being treated for postlaminectomy syndrome, lumbar spine degenerative disc disease, low back pain, sciatic nerve lesion, lumbar disc disorder, lumbar radiculopathy, lumbar-lumbosacral disc degeneration, hip bursitis, and pain in joint lower leg. On 9-3-2015, the injured worker reported ongoing low back pain radiating down both legs. His pain is rated 5 out of 10 with medications and 10 out of 10 without medications, which is unchanged since the prior visit. His activity level is unchanged. The physical exam (9-3-2015) revealed an antalgic gait, restricted lumbar flexion of 70 degrees and extension of 15 degrees, decreased lumbar lordosis, a post laminectomy scar, hypertonicity and tenderness of the bilateral paravertebral muscles, negative straight leg raise testing, and mild tenderness to the bilateral trochanteric bursa of the hip. There was a normal motor exam of the bilateral lower extremities and decreased sensation to light touch in the right anterolateral and posterior leg and foot dorsum. On 3-12-2007, an electromyography and nerve conduction study revealed no evidence of right or left L3-S1 (lumbar 3-sacral 1) lumbosacral radiculopathy. There was possible mild right sural nerve neuropathy versus mild sciatic nerve neuropathy without active denervation. On 3-21-2011, an MRI of the lumbar spine revealed multilevel disc protrusions with degenerative disc disease and annular tears especially at L4-5 (lumbar 4-5) and L5-S1 (lumbar 5-sacral 1) and bilateral L4-5 neuroforaminal stenosis with facet arthropathy. On 3-21-2011, x-rays of the right hip were unremarkable. Per the treating physician (9-3-2015 report), the injured worker has failed older versions of a spinal cord stimulator, but felt a new device with higher frequency capabilities in

addition to a slow taper of the injured worker's opiate medications was the best way to control his chronic pain. Surgeries to date have included percutaneous implantation of two spinal cord electrodes in 2008 and lumbar laminectomy. Treatment has included acupuncture, lumbar transforaminal epidural steroid injections, a lumbar epidural steroid injection, right sacroiliac joint injections, bilateral trochanteric bursa injections, and medications including short-acting pain (Norco), long-acting pain (MS Contin), topical pain (Flector patch), antidepressant Trazodone and Prozac), antianxiety (Buspar), muscle relaxant (Flexeril), and anti-epilepsy (Gabapentin). On 9-8-2015, the requested treatments included a spinal cord stimulator trial (Lead: 2, Nevro). On 9-17-2015, the original utilization review non-certified a request for a spinal cord stimulator trial (Lead: 2, Nevro).

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial (Lead: 2, Nevro): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

Decision rationale: The patient was injured on 04/10/12 and presents with back pain radiating from the low back down to both legs. The request is for spinal cord stimulator trial (Lead: 2, Nevro) for the lower back. The RFA is dated 09/08/15 and the patient's current work status is not provided. The MTUS Guidelines, pages 105 to 107, Spinal Cord Stimulators (SCS) section has the following: "Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions, and following a successful temporary trial." The MTUS Guidelines, page 101, Psychological Evaluations, IDDS and SCS (Intrathecal Drug Delivery Systems and Spinal Cord Stimulators) section states the following: "Recommended pre-intrathecal drug delivery systems (IDDS) and spinal cord stimulator (SCS) trial." The MTUS Guidelines, page 101, under Indications For Stimulator Implants has the following: 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. The patient has an antalgic gait, restricted lumbar flexion/extension, decreased lumbar lordosis, a post laminectomy scar, hypertonicity and

tenderness of the bilateral paravertebral muscles, and mild tenderness to the bilateral trochanteric bursa of the hip. He is diagnosed with postlaminectomy syndrome, lumbar spine degenerative disc disease, low back pain, sciatic nerve lesion, lumbar disc disorder, lumbar radiculopathy, lumbar-lumbosacral disc degeneration, hip bursitis, and pain in joint lower leg. The 09/03/15 report states that the "patient has previously failed older versions of a spinal cord stimulator but with a brand new device with high frequency capabilities as well as the fact that we are slowly tapering him down on his opiate medications, we feel that this is the best course of treatment to control patient's chronic pain." The patient previously failed SCS and there is no reason to trial another one. There is no support that the patients need to try different and new spinal cord stimulators. Therefore, the request is not medically necessary.