

Case Number:	CM15-0200618		
Date Assigned:	10/15/2015	Date of Injury:	01/21/2014
Decision Date:	11/30/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/13/2015

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 54 year old male who sustained an industrial injury on 01-21-2014. According to a progress report dated 08-27-2015, the injured worker reported headache, back pain and low back pain. Pain at its least was rated 4 in intensity on a scale of 1-10 and 8 at worst. Medications improved his condition. Pain was characterized as sharp and electricity. Pain was intermittent and radiating and was increased by bending and lifting. Pain was decreased by medications. He reported pain radiating down his legs in L4 distribution bilaterally right greater than left. The provider noted that the injured worker had failed medial branch block and lumbar epidurals steroid injection. The injured worker was status post lumbar epidural steroid injection at L5-S1 right on 02-09-2015 and status post medial branch block on 05-28-2015 without relief. He was interested in doing a spinal cord stimulator trial. Physical examination demonstrated decreased range of motion in all planes, positive straight leg raise bilaterally and positive bilateral lumbar radicular signs. Assessment included bilateral lumbosacral spondylosis, cervical spondylosis without myelopathy, bilateral unspecified thoracic lumbar neuritis radiculitis and brachial neuritis radiculitis not otherwise specified. The treatment plan included psychological evaluation referral and fluoroscopy guided spinal cord stimulator trial moderate sedation. Medications prescribed included Ibuprofen, Omeprazole, Gabapentin and Zofran. An authorization request dated 09-11-2015 was submitted for review. The requested services included spinal cord stimulator trial with fluoroscopy and sedation. On 09-22-2015, Utilization Review non-certified the request for spinal cord stimulator trial with fluoroscopy and sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial with fluoroscopy and sedation: Upheld

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

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

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 has the diagnoses of low back pain but not of failed back syndrome, CRPS, PVD, MS or spinal cord injury. The patient does have lumbosacral spondylosis and cervical spondylosis. These are not indications for SCS and therefore the request is not medically necessary.