

Case Number:	CM15-0201981		
Date Assigned:	10/16/2015	Date of Injury:	02/25/2011
Decision Date:	12/02/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	10/14/2015

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, District of Columbia,
 Maryland Certification(s)/Specialty: Anesthesiology, Pain
 Management

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 male, who sustained an industrial injury on 2-25-2011. The injured worker was being treated for lumbosacral spondylosis, degenerative lumbar-lumbosacral intervertebral disc, unspecified thoracic or lumbar neuritis or radiculitis, and spinal stenosis lumbar region. Medical records (7-21-2015, 8-18-2015, and 9-15-2015) indicate ongoing lower back and feet pain, which is unchanged. The injured worker rated his pain as 8 out of 10. The physical exam (7-21-2015) the physical exam also reveals a slow, antalgic gait and bilateral paraspinal tenderness with painful flexion and extension. The physical exam (8-18-2015, and 9-15-2015) reveals a slow and antalgic gait, but there is no documentation of a spinal assessment. On 5-8-2015, an MRI of the lumbar spine revealed evidence of lumbar strain. There are bilateral posterior facet joint synovitis at L4-5 (lumbar 4-5) and L5-S1 (lumbar 5-sacral 1), annular tears of the L3-4 (lumbar 3-4) and L4-5 intervertebral discs, and posterior disc protrusions at the L3-4 through L5-S1 levels. There is moderate to severe right-sided neural foraminal narrowing at L5-S1 with moderate bilateral neural foraminal narrowing at L4-5 and mild bilateral neural foraminal narrowing at L3-4 and on the left at L5-S1. Treatment has included physical therapy, a transcutaneous electrical nerve stimulation (TENS) unit, and medications including pain, muscle relaxant, and antiepilepsy. The treatment plan included a spinal cord simulator trial pending psychological clearance. On 9-23-2015, the original utilization review non-certified a request for a spinal cord simulator trail for the lumbar spine and psychological clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord simulator trial for lumbar spine: 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: With regard to spinal cord stimulators, the MTUS CPMTG states: "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. 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) Review of the documentation submitted for review did not reveal any indications for stimulator implantation. The injured worker does not have CRPS or failed back syndrome. There is no indication that the injured worker is not a surgical candidate. The request is not medically necessary.

Psych Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: With regard to spinal cord stimulators, the MTUS CPMTG states: "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. 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

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