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| Case Number: | CM15-0025084 | | |
| Date Assigned: | 02/17/2015 | Date of Injury: | 09/13/2011 |
| Decision Date: | 03/27/2015 | UR Denial Date: | 01/13/2015 |
| Priority: | Standard | Application Received: | 02/10/2015 |

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 female, who sustained an industrial injury on 9/13/11. Injury occurred when she tripped and fell, hitting her right knee and head on the edge of a table. The 1/26/12 right knee MRI impression documented a right lateral meniscus bucket handle tear and mild osteoarthritis. The patient underwent right knee surgery on 4/5/12. The 2/8/13 lumbar spine MRI impression documented a 2 mm central disc protrusion at L3/4 with mild hypertrophic facet changes, disc desiccation, and no evidence of spinal stenosis. There was a 2 to 3 mm posterior disc protrusion at L4/5 with moderate hypertrophic facet changes, disc desiccation, and mild to moderate right lateral recess stenosis. At L5/S1, there was a 3 mm disc protrusion with disc desiccation, mild hypertrophic facet changes, and mild lateral recess stenosis. The 5/22/14 pre-surgical psychological evaluation report noted the patient was a good candidate to undergo a spinal cord stimulator trial. The 12/9/14 treating physician report cited constant grade 5/10 low back and right leg aching with numbness. The injured worker also complained of pain in the right upper extremity, shoulder and upper arm, and right hip, thigh, knee, leg and foot. Pain was made worse with activity and movement. Pain got better by taking medications and resting. Pain without medications was reported 8-9/10. Current medications included gabapentin, tizanidine, Lyrica, and Norco. The physical exam indicated there were significant changes. The treating physician opined that the patient was an optimal candidate for spinal cord stimulator. She had underlying neuropathic pain and had not been responsive to conservative measures including three epidural injections, otherwise she may have to have spinal surgery. There is limited documentation in the records relative to conservative treatment, records suggest physical therapy

and TENS unit have been tried. On 1/13/15 Utilization Review non-certified Spinal Cord Stimulator trial with fluoroscopy guidance with MAC (Monitored Anesthesia Care) anesthesia. The rationale for non-certification noted a failure to meet guideline diagnostic criteria for the use of spinal cord stimulation. The MTUS, ACOEM Guidelines, (or ODG) were cited. On 2/10/15, the injured worker submitted an application for IMR for review of Spinal Cord Stimulator trial with fluoroscopy guidance with MAC (Monitored Anesthesia Care) anesthesia.

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 guidance with MAC (Monitored Anesthesia Care) anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS).

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

Decision rationale: The California MTUS recommend the use of spinal cord stimulator only for selected patients in cases when less invasive procedures have failed or are contraindicated. Indications included failed back syndrome, defined as persistent pain in patients who have undergone at least one previous back surgery, and complex regional pain syndrome. Consideration of permanent implantation requires a successful temporary trial, preceded by psychological clearance. Guideline criteria have not been met. This patient has not undergone back surgery, although the treating physician indicated it might be required. There is no documentation suggestive of complex regional pain syndrome. Psychological clearance for this procedure was provided in May 2014, but on-going psychological care has been recommended. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, beyond medications, and failure has not been submitted. Therefore, this request is not medically necessary.