

<b>Case Number:</b>	CM15-0028373		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	04/23/2002
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 58-year-old male, with a reported date of injury of 04/23/2002. The diagnoses include cervical spondylosis, brachial neuritis, cervical spondylosis without myelopathy, and neck pain. Treatments included an electromyography, a computerized tomography (CT) scan of the cervical spine, an MRI of the cervical spine, physical therapy, transcutaneous electrical nerve stimulation (TENS) unit, and oral medications. The progress report dated 02/02/2015, indicates that the injured worker complained of increased neck pain and difficulty sleeping on a pillow. He still experienced left trapezius, triceps, left thumb, index, and long finger pain. There was also a burning sensation in the fingers on the left side. The objective finding included left trapezial tenderness and left medial scapula tenderness; a normal inspection and palpation of the cervical spine; normal cervical lordosis; normal cervical spine range of motion; and absent biceps and triceps deep tendon reflexes. The treating physician requested one spinal cord stimulator trial. The rationale for the request was not indicated. On 02/12/2015, Utilization Review (UR) denied the request for one spinal cord stimulator trial, noting that there was no evidence of complex regional pain syndrome or failed low back surgery syndrome and the injured worker had not fully exhausted all possible conservative means of treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Spinal cord stimulator trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator Page(s): 106-107.

**Decision rationale:** According to MTUS guidelines, spinal cord stimulator “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. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain. (Mailis-Gagnon-Cochrane, 2004) (BlueCross BlueShield, 2004) See indications list below. 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 non-receptive 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) There is no documentation that the patient is suffering from any of the above indications of spinal cord stimulator. There is no evidence of failed previous surgery, radiculopathy or true neuropathic pain. There is no documentation of failure of more conservative therapies. Therefore, the request for spinal cord stimulator trial is not medically necessary.