

Case Number:	CM15-0223156		
Date Assigned:	11/19/2015	Date of Injury:	04/19/2008
Decision Date:	12/30/2015	UR Denial Date:	10/23/2015
Priority:	Standard	Application Received:	11/13/2015

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:

This is a 50 year old male with a date of injury of April 19, 2008. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar radiculopathy status post lumbar discectomy and laminectomy, and post-laminectomy syndrome. Medical records dated August 13, 2015 indicate that the injured worker complained of pain rated at a level of 7 out of 10. A progress note dated October 9, 2015 documented complaints of pain rated at a level of 8 out of 10. Per the treating physician (October 9, 2015), the employee had permanent work restrictions that included no repetitive bending at the waist, no lifting greater than twenty pounds, and must be able to sit and stand as needed. The physical exam dated August 13, 2015 reveals spinous process tenderness at L3-L5, facet tenderness at L3-L5 bilaterally, positive straight leg raise bilaterally, positive FABER test bilaterally, decreased sensation over the medial calf, lateral calf and first toe on the left side, and dysesthesias present over the lower limbs bilaterally. The progress note dated October 9, 2015 documented a physical examination that showed no changes since the examination performed on August 13, 2015. Treatment has included lumbar epidural steroid injection, medications (Hydrocodone-Acetaminophen, Celebrex, Gabapentin, and Lunesta), and lumbar spine surgery. The utilization review (October 23, 2015) non-certified a request for spinal cord stimulator under fluoroscopic guidance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal Cord Stimulator Under Fluoroscopic Guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The California MTUS section on the requested service states: 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 does have failed back syndrome with persistent pain complaints. However there is no documented pre-trial psychological assessment, which is necessary for this intervention. Therefore, the request is not medically necessary.