

<b>Case Number:</b>	CM15-0031673		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	02/28/2008
<b>Decision Date:</b>	04/15/2015	<b>UR Denial Date:</b>	02/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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 55 year old male with an industrial injury dated 02/28/2008. He reports being a truck driver for 18 years. His job duties included frequent long hours behind the wheel and frequent loading and unloading cargo. He was complaining of low back and hip pain. Physical exam revealed diffuse tenderness to palpation over the lumbar 4 - 5 and lumbar 5 - sacral 1 lumbar interspaces. There was muscular guarding over the bilateral erector spinae muscle and gluteus maximus region. Range of motion of the lumbar spine was limited to between 50-60% of normal range. Straight leg raising was positive bilaterally. Prior treatment includes diagnostic lumbar 4-5 and lumbar 5-sacral 1 facet injection treatment, physical therapy, acupuncture, chiropractic manipulations, radiofrequency neurotomy, sacroiliac joint injections, medications and rehabilitation treatment. The provider documents he is currently not recommended for surgical intervention at this time. A trial of spinal cord stimulator was recommended. Diagnosis: Chronic intractable low back pain; Lumbar degenerative disc disease at lumbar 4-5 and lumbar 5-sacral 1; Lumbar disc protrusion at lumbar 5-sacral 1; Lumbar facet joint arthropathy at lumbar 4-5 and lumbar 5-sacral 1; Bilateral lumbar radiculopathy; Chronic reactive clinic depression. On 02/05/2015 the request for trial of spinal cord stimulator was non-certified by utilization review. ODG was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trial of spinal cord stimulator:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator Page(s): 105.

**Decision rationale:** California MTUS guidelines indicate that the criteria for a trial of a spinal cord stimulator includes individuals who have had failed back surgery syndrome. The attached medical record indicates the injured employee has had a variety of conservative treatments and injections however there is no history of having failed to improve with a previous lumbar surgery procedure. Considering this, the request for a trial of spinal cord stimulators is not medically necessary.