

<b>Case Number:</b>	CM15-0044197		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	08/24/2009
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	02/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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 year old male, who sustained an industrial injury on August 24, 2009. He reported heard and felt a pop in his lower back along with shooting pain into his legs. The injured worker was diagnosed as having lumbar 3-lumbar 4 disc herniation with central stenosis and bilateral neural foraminal narrowing, lumbar 4-lumbar 5 central stenosis and marked neural foraminal narrowing with pressure over the lumbar 4 nerve roots, lumbosacral sprain with radicular symptoms, status post decompression and fusion of lumbar 3-lumbar 5, and status post microdiscectomy at lumbar 3-lumbar 4 and lumbar 4-lumbar 5. Treatment to date has included x-rays, urine drug screening, oral and topical pain medications, and antidepressant medication. On December 15, 2014, the injured worker complains of continued constant low back pain radiating to the bilateral lower extremities. Associated symptoms include numbness and tingling in the low back and left lower extremity. The physical exam revealed decreased lumbar range of motion. The treatment plan includes physical therapy for the lumbar spine, psychiatric evaluation and spinal cord stimulator trial, pain medications, and to remain off work.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy, Lumbar, 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98- 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** According to MTUS guidelines, Physical Medicine is “Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment (Fritz, 2007).” The frequency of the treatment should be reduced from 12 to 3 or less sessions. More sessions will be considered when functional and objective improvement is documented. In addition, there is no documentation that the patient cannot perform home exercise. Therefore, the request for 12 physical therapy sessions is not medically necessary.

**Dorsal column stimulator, trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulator (SCS) Page(s): 101.

**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 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) There is no documentation that the patient is suffering from any of the above indications of spinal cord stimulator. There is no documentation that less invasive therapies failed to improve the patient. There is no evidence of failed previous surgery, radiculopathy or true neuropathic pain. Therefore, the request for Dorsal column stimulator, trial is not medically necessary.

**Psychiatric evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Assessing Red Flags and Indication for Immediate Referral, Chronic pain programs, early intervention Page(s): 171, 32-33.

**Decision rationale:** According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a psychiatry specialist. In this case, there is consideration of a spinal cord stimulator for failed back syndrome; however, the documentation should include the reasons, the specific goals and end point for a referral to psychiatric specialist. Therefore, the request for psychiatric evaluation is not medically necessary.