

Case Number:	CM15-0053155		
Date Assigned:	03/26/2015	Date of Injury:	08/03/2009
Decision Date:	05/12/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/20/2015

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 57-year-old male who sustained an industrial injury on 8/3/09. The mechanism of injury was not documented. The patient has been diagnosed with chronic low back pain, lumbar degenerative disc disease, myofascial pain, and lumbar radiculitis. Past surgical history was negative. The 1/22/15 treating physician report documented constant grade 4/10 low back pain radiating to the left leg, worsened by sitting and standing. Pain was improved by medications and swimming or moving about. Conservative treatment included six epidural steroid injections with partial pain relief lasting 4 to 6 months. A discogram in 2014 was negative. Current medications included Lyrica and Oxycodone. Lumbar spine exam documented normal range of motion limited by pain, negative straight leg raise, normal gait, intact sensation, normal motor, and symmetrical reflexes. Imaging documented annular tears at L4/5 and L5/S1, paracentral disc bulges at L1/2 and L4/5, and neural foramen patent at all levels. The assessment included lower extremity neuralgia, lumbar radiculitis in the left L5 versus S1 distribution, lumbar disc degeneration, lumbar spondylosis, and annular tears L4/5 and L5/S1. The treatment plan recommended continued medications. Authorization was requested for a spinal cord stimulator trial to reduce opiate consumption and improve quality of life and function, and post-op follow-up x 3. The 2/27/15 utilization review non-certified the request for spinal cord stimulator as the patient did not meet guideline indications for use.

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: The Claims Administrator did not cite any medical evidence for its decision.

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 injured worker presents with chronic radicular lower back pain, He has not undergone lumbar surgery or been diagnosed with complex regional pain syndrome. Additionally, there is no evidence of a psychological clearance. Therefore, this request is not medically necessary.

Post-Op Follow-Up x 3: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back $\frac{1}{2}$ Lumbar & Thoracic: Office visits.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.