

Case Number:	CM15-0053740		
Date Assigned:	03/27/2015	Date of Injury:	07/01/2003
Decision Date:	07/21/2015	UR Denial Date:	03/03/2015
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 45-year-old male who sustained an industrial injury on 7/1/03. Injury occurred when he bent over to pick up a tow bar. Past surgical history was positive for L4/5 and L5/S1 lumbar discectomy on 2/4/04, lumbar fusion at L4/5 and L5/S1 on 5/23/12, and a subsequent fusion at the L3/4 level on 9/22/14. The injured worker was diagnosed with lumbar post-laminectomy syndrome. Conservative treatment to date included medications, bracing, activity modifications, off work, surgery, pain management, and epidural steroid injections. The 4/2/12 lumbar spine MRI impression documented mild loss of disc height at L2/3 and residual broad-based central disc protrusion with mild facet arthropathy contributing to mild spinal canal stenosis. At L3/4, there was mild to moderate disc height loss and 2-3 mm disc bulge with mild facet arthropathy contributing to mild spinal canal stenosis. At L5/S1, there were surgical changes with moderate to severe right sided loss of disc height and significant progression of right sided endplate marrow edema. There was a 3-4 mm disc bulge/osteophyte with mild to moderate left sided facet arthropathy contributing to mild to moderate facet arthropathy and suspected left posterior vacuum phenomenon/gas formation rather than osteophyte or extruded disc. At L5/S1, there was moderate posterior loss of disc height, 4-5 mm disc bulge with overlapping 2-3 mm retrolisthesis and mild to moderate facet arthropathy that contributed to mild to moderate foraminal stenosis. The 12/23/14 initial pain management evaluation report cited daily low back pain radiating into the left lower extremity. There was burning pain, pins and needles, and throbbing reported in the left thigh, foot, toes and bottom of foot. The pain increased with activity. The injured worker reported low back spasms and buckling of the left knee with associated falls. Functional difficulty was reported in activities of daily living with walking limited to 1-2 blocks. Current medications included Percocet 10/325 mg every 4 hours,

OxyContin 30 mg every 6 hours, Lyrica 100 mg 3 times a day, diazepam 10 mg as needed, meloxicam 15 mg daily, and omeprazole 40 mg twice daily. Medications allowed him to be somewhat functional. Physical exam documented the injured worker to be in distress and wearing a lumbar brace. He moved about slowly in obvious pain with a limp favoring the left lower extremity. Lumbar spine exam documented paraspinal muscle tenderness and spasms, bilateral sacroiliac joint tenderness, and left sciatic notch tenderness. Lumbar range of motion was restricted. There was decreased left L5 and S1 dermatomal sensation, normal deep tendon reflexes, and positive left straight leg raise. There was 4/5 left tibialis anterior, extensor hallucis longus, and common toe extensor weakness. The diagnosis included failed back surgery syndrome, post-laminectomy syndrome, chronic radiculopathy, and radiculitis in the left lower extremity. The treatment plan recommended a trial of spinal cord stimulator which had been recommended in the past by his spine surgery and pain management physicians. Authorization was requested for spinal cord stimulator trial and associated surgical and psychological evaluation prior to trial of spinal cord stimulator. The 3/3/15 utilization review non-certified the spinal cord stimulator trial and associated surgical and psychological evaluation prior to trial of spinal cord stimulator as there was no documentation that the injured worker had participated in conservative treatment other than taking oral medications or documentation of less invasive procedures performed.

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 Spinal cord stimulator (SCS) Page(s): 105.

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 fully met. This injured worker presents with persistent low back and radicular leg symptoms despite 3 prior lumbar surgeries and epidural steroid injections. There is no documentation that the patient has obtained psychological clearance. Therefore, this request for a spinal cord stimulator (SCS) trial is not medically necessary as this time.

Surgical and psychological evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, Chronic Pain Treatment Guidelines Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cordstimulators) Page(s): 101.

Decision rationale: The California MTUS guidelines recommend psychological evaluations prior to spinal cord stimulator trial. Guidelines state that surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, and activity limitations due to radiating leg pain. Guidelines require clear clinical, imaging, and electro-physiologic evidence of a lesion that has shown to benefit in the short and long term from surgical repair. Failure of time and an adequate trial of conservative treatment to resolve disabling radicular symptoms must be documented. This injured worker presents with persistent function-limiting low back and radicular leg symptoms. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Current documentation supports proceeding with a spinal cord stimulator trial and psychological evaluation prior to the trial is consistent with guidelines. However, there is no current clinical evidence correlated with imaging that supports the need for a surgical consult at this time. There is no rationale documented in the available records to support the surgical request. Therefore, this request is not medically necessary.