

Case Number:	CM15-0080816		
Date Assigned:	05/01/2015	Date of Injury:	11/17/2003
Decision Date:	06/11/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/27/2015

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: Georgia

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 57-year-old male, with a reported date of injury of 11/17/2003. The diagnoses include failed low back surgery syndrome, status post L4-S1 fusion, lumbar radiculopathy, and left sacroiliitis. Treatments to date have included an MRI of the lumbar spine on 12/21/2013, oral medications, and left sacroiliac joint injection. The progress report follow-up dated 03/23/2015 indicates that the injured worker complained of low back and left leg pain. He reported that he was doing worse. The injured worker rated his pain 7-8 out of 10. Without medications, the injured worker rated his pain 7 out of 10 and with medications 4 out of 10. He reported that the medications allowed improvement in function, and helped increased his walking distance by about 30 minutes. An examination of the lumbar spine showed tenderness to palpation of the lumbar paraspinals with spasm, decreased range of motion, positive facet challenge of the bilateral lumbar spine, decreased sensation throughout the left lower extremity, and positive left straight leg raise test. The treating physician requested an outpatient spinal cord stimulator trial. It was noted that the injured worker had failed treatment in the past (injections, therapy, lumbar surgery), and said that the injections in the past did not provide any relief. The injured worker was hesitant about trying Gabapentin, and did not want to try other neuropathic medications, because he had tried other anti-depressants in the past that caused him to have paranoia and walk around with anxiety. On 03/27/2015, Utilization Review (UR) denied the request and noted that non-invasive options are still available and that an invasive procedure such as a spinal cord stimulator trial should await completion of non-invasive options. The MTUS Guidelines were cited.

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 stimulators (SCS) Page(s): 105-107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines S.

Decision rationale: Spinal Cord Stimulator Trial is not medically necessary. Per Ca MTUS 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. 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) Additionally, the guidelines indicate that the use of a spinal cord stimulator is a last resort when all other conservative attempts to control the patient's pain have failed, (for example, various medications including neuroleptics for neuropathic pain, injections, physical therapy.)