

<b>Case Number:</b>	CM15-0084494		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	07/13/2011
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 38 year old male, who sustained an industrial injury on 7/13/2011. He reported injury to the neck, right shoulder, and low back while performing lifting/pushing/pulling activity in addition to skin discoloration due to chemical exposure. He is status post shoulder arthroscopy and lumbar surgery. There is history of gastric symptoms from the use of Naprosyn. Diagnoses include cervical radiculopathy, lumbosacral radiculopathy, shoulder impingement and chemical dermatitis not elsewhere classified. Treatments to date include physical therapy, epidural steroid injections. Currently, he complained of continued low back pain with bilateral lower extremity numbness and right shoulder pain. He is status post epidural steroid injection approximately one month prior with only some relief reported. On 3/25/15, the physical examination documented tender lumbar muscles with decreased sensation in lower extremities, weakness of the knees, and decreased right ankle reflex. There was a positive right side straight leg raise test. The diagnoses included lumbar post laminectomy syndrome, lumbar radiculopathy, and right shoulder arthropathy. The plan of care included a psychological evaluation for a spinal cord stimulator trial, and a request for insertion of a spinal cord stimulator for trial with two leads.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar 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 spinal cord stimulators (SCS), pages 38.

**Decision rationale:** MTUS guidelines states that spinal cord stimulators are only recommended for selected patients as there is limited evidence of its functional benefit or efficacy for those failed back surgery syndrome and complex regional pain syndrome. It may be an option when less invasive procedures are contraindicated or has failed. Criteria include psychological evaluations screening along with documented successful trial prior to permanent placement for those patients with specific diagnoses of failed back syndrome; complex regional pain syndrome; post-amputation pain; post-herpetic neuralgia; spinal cord dysesthesia/injury; multiple sclerosis or peripheral vascular diseases. Submitted reports have not demonstrated support to meet these criteria as no medical clearance from a psychologist has been noted and no failed conservative treatment or ADL limitations are documented to support for SCS. The Lumbar spinal cord stimulator trial is not medically necessary and appropriate.