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| Case Number: | CM14-0137999 | | |
| Date Assigned: | 09/05/2014 | Date of Injury: | 08/11/2004 |
| Decision Date: | 06/05/2015 | UR Denial Date: | 08/14/2014 |
| Priority: | Standard | Application Received: | 08/26/2014 |

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 54-year-old female who sustained an industrial injury on 8/11/04. Injury occurred when she went to lift a box while sitting in a chair and felt a pop in her back. She underwent an L5/S1 microdiscectomy/laminectomy in January 2005 and an artificial disc replacement surgery from L3 through S1 in February 2006. The 8/7/14 treating physician report cited left greater than right low back pain and radiating lower extremity pain, and constant neck pain in which she was unable to sleep. Pain was reported more tolerable on the current medication program. Pain was exacerbated with walking, standing, and sitting. Pain was alleviated with medications. Physical exam documented significant loss of cervical and lumbar range of motion, and give-way weakness throughout the upper and lower extremities but no focal motor deficits were appreciated. There was numbness in both hands in the bilateral C6 and C7 dermatomal distributions. Upper and lower extremity deep tendon reflexes were +1 and symmetrical. She had positive bilateral Spurling's tests, no clonus, and positive bilateral Tinel's at the carpal tunnels. The diagnosis included cervical post-laminectomy syndrome, cervical radiculitis, and spondylosis, lumbar post-laminectomy syndrome and lumbar radiculitis, cervical and lumbar intervertebral disc degeneration, and carpal tunnel syndrome. The treatment plan recommended medication refills, physical/aquatic therapy, repeat bilateral L4/5 and L5/S1 transforaminal epidural steroid injections, cervical paraspinal and trapezius trigger point injections, pain psychology evaluation and treatment, repeat lumbar MRI to assess for new disc herniation, and implantation of percutaneous peripheral neurostimulator and intraoperative programming. The percutaneous neurostimulator is placed and typically stays on for 4 to 7 days

followed by in-office removal. The recommendation was to place up to 3 units over a 30-day period. The 8/14/14 utilization review non-certified the request for spinal cord stimulator implementation or intraoperative programming as there was no documentation of a spinal cord stimulator trial or current clinical finding demonstrating radiculopathy on examination.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intraoperative Programming of Peripheral Neurostimulator: 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 Percutaneous electrical nerve stimulation (PENS) Page(s): 97.

Decision rationale: The California MTUS guidelines state that percutaneous electrical nerve stimulation (PENS) is not recommended as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. Guidelines state that there is a lack of high quality evidence to prove long-term efficacy. Guideline criteria have not been met. This injured worker presented with chronic neck and low back pain radiating to both lower extremities. She reported that the new medication regime was providing better pain management. There was no documentation of a therapeutic exercise and TENS unit trial and failure. There was no documentation of her participation in a current program of evidence-based functional restoration. Given the failure to meet guideline criteria for percutaneous peripheral neurostimulator, the associated request for intraoperative programming is not medically necessary.