

Case Number:	CM15-0114575		
Date Assigned:	06/22/2015	Date of Injury:	09/01/2011
Decision Date:	07/21/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/15/2015

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, Indiana, Oregon
 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 53 year old female, who sustained an industrial injury on 9/1/11. She reported pain in her lower back. The injured worker was diagnosed as having 2 level lumbar arthrodesis, bilateral sacroiliac joint arthrodesis and residual back pain. Treatment to date has included a lumbar MRI on 11/19/11 showing degenerative disc disease at L4-L5, a lumbar epidural injection on 3/21/12, a right sacroiliac joint injection x 2, physical therapy and a TENs unit. As of the PR2 dated 5/7/15, the injured worker reports low back pain. She had stopped taking the Oxycodone and was only taking OxyContin at night, but she still had significant pain flares. She is now requesting a refill on the Oxycodone. Objective findings include tenderness over the lumbosacral junction and decreased lumbar range of motion. The treating physician requested a spinal cord stimulator trial to the lumbar spine, a psych consultation for clearance and a cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial to the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines spinal cord stimulation Page(s): 106-107.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, pages 106-107 states that it is recommended only for selected patients when less invasive procedures have failed or are contraindicated for specific conditions and when there is a successful temporary trial. Those conditions are as stated below. 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. On this case the exam note from 3/12/15 documents 70% improvement in back pain since the fusion operating in November 2014. Based on this the worker has not felt to have failed back syndrome. There is no identification of other conditions where spinal cord stimulator is recommended. Based on this the request is not medically necessary.

Associated surgical service: Psych consultation for clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd edition, Chapter 7 Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines spinal cord stimulator Page(s): 106-107.

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

Associated surgical services: Cold therapy unit: 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) .

Decision rationale: CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG Low Back section, cold/heat packs is recommended as an option for acute pain. It is recommended for at home application of cold packs for the first few days of acute complaint. The ODG does not recommend a motorized hot cold therapy unit such as vascutherm as cold packs is a low risk cost option. Therefore the request is not medically necessary as the operation was months ago.