

Case Number:	CM15-0114864		
Date Assigned:	06/23/2015	Date of Injury:	06/20/2008
Decision Date:	07/22/2015	UR Denial Date:	06/09/2015
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: North Carolina

Certification(s)/Specialty: Family Practice

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 61 year old male who sustained an industrial injury on 6/20/08 when he took a misstep and fell face first into a wall, injuring his back. He was medically evaluated and had x-rays, computed tomography and MRI of the lumbar spine (none of the results are available). He was told he had L5-S1 disc herniation and was on bed rest but the pain persisted. Electromyography/ nerve conduction studies showed "nerve damage" causing pain in the left leg (results not available). In 2009 he underwent a one level fusion with hardware. After the surgery the left leg pain improved but the low back pain worsened. Instrumentation was felt to be the cause of the increased pain and he had a second surgery to remove the hardware. This improved the back pain leaving his left lower limb with significant pain which was aggravated by two or three falls, caused by tripping over the left foot. He complains of left leg pain with left ankle weakness. On physical exam there was tenderness on palpation and tightness over the left more than right lumbar and lumbosacral paraspinal musculature, as well as over the left greater than right quadratus lumborum and left paraspinal musculature. There was decreased range of motion and decreased sensation in S1 left. His pain level is 7/10 with medications and 8.5/10 without medications. Sleep quality is poor. Medications are Effexor, gabapentin, hydrocodone-acetaminophen, Opana, tizanidine, clonazepam. Diagnoses include pain disorder with both psychological factors and orthopedic condition; radiculopathy; post lumbar laminectomy syndrome; depression; chronic regional myofascial pain syndrome; status post L5-S1 fusion; gait impairment with history of falls. Treatments to date include functional capacity evaluation; transforaminal steroid injections (9/2014) with 70% improvement in leg pain for five months;

medications give partial relief; L2 ramus communicans block (2/9/15); acupuncture; inconsistent physical therapy; limited aqua therapy which was helpful; behavioral pain management; medications. In the progress note dated 5.18.15 the treating provider's plan of care includes neurological spinal cord stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral for neuro SCS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289-291.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SCS Page(s): 105-107.

Decision rationale: The California MTUS chapter on spinal cord stimulators states: 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) In addition, the patient must have psychological clearance. This is not included in the provided clinical documentation and the request is therefore denied as the need for SCS is not established therefore referral is not medically necessary.