

<b>Case Number:</b>	CM14-0140680		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	01/14/2008
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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: 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 59 year old female, who sustained an industrial injury on January 14, 2008. The medical records indicate that the injured worker is undergoing treatment for lumbar myofascial strain, lumbar degenerative disc disease, right wrist contusion, right trigger finger, left wrist contusion and sprain, left carpal tunnel syndrome, chronic pain syndrome, left de Quervain's tenosynovitis, anxiety and depression. The injured worker was not working. Documentation dated August 7, 2014 notes that the injured worker reported constant stinging low back pain which radiated down the left lower extremity into the foot and toes. Associated symptoms include numbness and tingling. The pain was rated a 5-6 out of 10 with medications. The injured worker also noted decreased bilateral wrist strength and stiffness with a constant aching pain. There was also more numbness noted in the fingers of the right hand. The injured workers mood was rated a 3-4 out of 10 with medications. The injured worker confirmed that she is not harm to herself or others. Examination of the bilateral wrists revealed a decreased range of motion and diminished grip strength. Examination of the lumbar spine revealed pain to palpation over the lumbosacral junction. Range of motion was decreased and painful. A straight leg raise test was positive bilaterally. Treatment and evaluation to date has included medications, radiological studies, electro diagnostic studies, urine drug screen, psychological testing, physical therapy, aquatic therapy, bilateral hand surgery and a lumbosacral fusion. Current medications include Norco, MS Contin, Cymbalta, Amitiza and Morphine Sulfate. Current requested treatments include a consultation with a psychologist (cognitive behavior therapy-clearance for spinal cord stimulator) and a spinal cord stimulator trial. Utilization Review documentation dated

August 19, 2014 partially certified the consultation with a psychologist-clearance for spinal cord stimulator (original request was for cognitive behavior therapy-clearance for spinal cord stimulator) and non-certified a spinal cord stimulator trial.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Consultation with a psychologist (cognitive behavioral therapy/clearance for spinal cord stimulator):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

**Decision rationale:** The California MTUS section on SCS therapy 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) The patient does has a documented history of failed back surgery. Psychological clearance would be necessary before SCS trial. Therefore, the request is medically necessary.

**Spinal cord stimulator trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

**Decision rationale:** The California MTUS section on SCS therapy 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) The patient does has a documented history of failed back surgery. Psychological clearance would be necessary before SCS trial. Therefore, the request is not medically necessary.