

<b>Case Number:</b>	CM14-0003572		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	05/17/2000
<b>Decision Date:</b>	06/23/2014	<b>UR Denial Date:</b>	12/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 53 year old female who was injured on 05/17/2000. Mechanism of injury is unknown. Prior treatment history has included the patient undergoing anterior discectomy and cervical fusion in 2002, revision C4-7 anterior discectomy, cervical fusion in 2010, right vocal cord paralysis with dysphonia with microsuspension laryngoscopy and Radiess Voice Gel injection, right true vocal fold to medialize the cord on 06/04/2013, status post laminectomy in 2002 at L5-S1, L3-S1 posterior fusion in 2010 and L1-L2 posterior fusion and correction of kyphotic deformity in 2012. She also had gastric bypass in 2005. An updated medication list reveals the patient's medications are as follows: 1. Morphine sulphate ER 2. Hydromorphone 3. Cyclobenzaprine 4. Tizanidine 5. Pilocarpine 6. Vitamin B12 7. Lidoderm 5% patch 8. Ambien 9. Lacrisert 5 mg ophthalmic 10. Restasis ophthalmic 11. Flonase 12. Astelin nasal spray 13. ProAir inhaler 14. Albuterol PR-2 dated 10/17/2013 documented the patient with complaints of increasing knee pain with locking. Objective findings reveal she continues with severe periodontal disease with teeth cracking. She has bilateral arm and abdominal skin folds with underlying skin breakdown with fungal infection. She has bilateral knee joint tenderness with joint effusion. Diagnostic Impression: 1. Cervical post laminotomy pain syndrome 2. Lumbar post laminotomy pain syndrome 3. Morbid Obesity 4. Obstructive sleep apnea 5. Venous insufficiency 6. History of Sjogren's disorder 7. Major depressive disorder with suicidal ideation and attempt in 2007 8. Right shoulder impingement syndrome 9. Bilateral upper extremity entrapment neuropathy 10. History of narcotic dependency 11. Ventral abdominal hernia 12. Cerebrovascular accident in 2007 13. Alopecia 14. Severe dental decay 15. Severe peripheral neuropathy 16. Bilateral knee internal derangement Treatment Plan: (Pertaining to request) Patient remains pending car lift for her electric wheelchair. Request for outpatient peripheral nerve stimulation has been denied. UR report dated 12/17/2013 denied the request for car lift

for electric wheelchair because the records do not contain information at this time to support the need for this equipment or an evaluation, which has been done to indicate that the patient could not operate and benefit from. The request for percutaneous electrical nerve stimulator x 3 treatments was denied because the records do not provide a rationale or additional information subsequent to the prior physician non-certification of this request. There is no indication of a program of evidenced based functional restoration. For these reasons, it is recommended this request be non-certified.

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

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

#### **PERCUTANEOUS ELECTRICAL NERVE STIMULATOR X 3 TREATMENTS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PERCUTANEOUS ELECTRICAL NERVE STIMULATION (PENS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Percutaneous electrical nerve stimulation (PENS), Page 97.

**Decision rationale:** As per CA MTUS guidelines, Percutaneous Electrical Nerve Stimulator is not recommended as a primary 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 unsuitable / contraindicated. There is a lack of high quality evidence to prove long-term efficacy. PENS is generally reserved for patients who fail to get pain relief from TENS. In this case, there is no evidence of the above criteria being met. Therefore, the request is not medically necessary and appropriate.

#### **CAR LIFT FOR WHEEL CHAIR: 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), Knee & Leg, Durable Medical Equipment (DME).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Durable Medical Equipment (DME)

**Decision rationale:** CA MTUS guidelines do not discuss the issue in dispute and hence ODG have been consulted. The medical records fail to show an evaluation for such necessity. Furthermore, there is insufficient information to indicate that the patient could operate and benefit from it. Therefore, the medical necessity of the requested device is not established.