

<b>Case Number:</b>	CM15-0168423		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	01/04/2014
<b>Decision Date:</b>	10/14/2015	<b>UR Denial Date:</b>	08/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 25-year-old male, who sustained an industrial injury on 01-04-2014. He has reported injury to the low back. The diagnoses have included history of lumbar degenerative disc disease; lumbar radiculopathy; lumbar facet arthropathy; right hip pain; and myofascial pain. Treatment to date has included medications, diagnostics, TENS (transcutaneous electrical nerve stimulation) unit, lumbar facet blocks, chiropractic therapy, and physical therapy. Medications have included Norco, Mobic, Quazepam, Ambien, Flexeril, and Topamax. A progress report from the treating physician, dated 07-17-2015, documented a follow-up visit with the injured worker. The injured worker reported continued axial lower back pain; and he has some pain and function benefit from his current medications without adverse effect. Objective findings included tenderness to the lumbar paraspinal muscles; tenderness to lumbar facet L4-5 bilaterally; positive lumbar facet loading; negative straight leg raising test bilaterally; and he has failed conservative care with physical therapy, non-steroidal anti-inflammatory, TENS, and muscle relaxants alone. It is noted in a progress note, dated 05-26-2015, that the injured worker did not get significant relief from lumbar facet injections; he reported 15% pain reduction. The treatment plan has included the request for percutaneous electrical nerve stimulator (Neurostimulator) x 4 separate treatments (each treatment is 5 days continuous percutaneous nerve stimulation) over the course of 30 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percutaneous electrical nerve stimulator (Neurostimulator) x 4 separate treatments (each treatment is 5 days continuous percutaneous nerve stimulation) over the course of 30 days:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, under Percutaneous electrical nerve stimulation (PENS).

**Decision rationale:** The patient was injured on 01/04/14 and presents with axial low back pain. The request is for PERCUTANEOUS ELECTRICAL NERVE STIMULATOR (NEUROSTIMULATOR) X 4 SEPARATE TREATMENTS (EACH TREATMENT IS 5 DAYS CONTINUOUS PERCUTANEOUS NERVE STIMULATION) OVER THE COURSE OF 30 DAYS. The utilization review rationale is that "the claimant is pending 4 bilateral facet joint injections and it is felt that the outcome of facet joint injection should first be assessed prior to considering the necessity for this intervention." There is no RFA provided and the patient's current work status is not provided. MTUS/ACOEM Guidelines, Chapter 12, Low Back Complaints Chapter under Physical Methods Section, page 300 states: "Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy." ODG-TWC Guidelines, Pain Chapter, under Percutaneous electrical nerve stimulation (PENS) Section states, "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. There is a lack of high quality evidence to prove long-term efficacy." The patient has tenderness to the lumbar paraspinal muscles, tenderness to lumbar facet L4-5 bilaterally, and a positive lumbar facet loading. He is diagnosed with lumbar degenerative disc disease; lumbar radiculopathy; lumbar facet arthropathy; right hip pain; and myofascial pain. Treatment to date has included medications including NSAIDs, diagnostics, TENS (transcutaneous electrical nerve stimulation) unit, lumbar facet blocks, chiropractic therapy, and physical therapy. In this case, the patient has failed multiple treatment modalities, including TENS. ODG guidelines support a trial of PENS as an adjunct to a functional restoration program. Therefore, the request IS medically necessary.