

<b>Case Number:</b>	CM15-0211572		
<b>Date Assigned:</b>	10/30/2015	<b>Date of Injury:</b>	06/26/2010
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2015

### 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: Texas, California

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:

This is a 49 year old male patient, who sustained an industrial injury on 6-26-2010. He sustained the injury while climbing out of a container. The diagnoses include cervical disc disease with radiculitis, right shoulder impingement syndrome, and status post lumbar fusion, still very symptomatic with radiculitis. Per the doctor's note dated 9-25-2015, he had complains of constant and severe low back pain, rated 7 out of 10 with medications (unchanged from pain rating 6-05-2015), with radiation to both legs, with numbness, tingling and weakness. He also reported constant right shoulder pain, chronic headaches, stress, insomnia, and nausea. He reported intolerable pain when trying to wean Norco. Physical exam revealed the right shoulder-tenderness at the subacromial space with limited range of motion; the lumbar spine- limited range of motion, positive sitting root test, and positive sciatic tension test. The medications list includes norco, neurontin and prilosec. He has undergone lumbar spine fusion and right shoulder arthroscopy. His work status was permanent and stationary. Function with activities of daily living was not described. Treatment to date has included diagnostics, right shoulder surgery in 6-2014, lumbar spinal surgery in 1-2014, lumbar epidural steroid injections, therapy, and medications. The treating physician noted failed treatments as transcutaneous electrical nerve stimulation unit, physical therapy, pharmacological therapy, and lumbar spinal surgery. The treatment plan included percutaneous electrical nerve stimulator treatments, in an effort to reduce pain level, decrease medication consumption, reduce overall inflammation, and improve functional levels, noting that the procedure would include placement of the neurostimulator power generator unit and percutaneous implantation of an electrode array. On 10-12-2015

Utilization Review non-certified 4 Sessions of percutaneous electrical nerve stimulator treatments.

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

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

#### **4 Sessions of percutaneous electrical nerve stimulator (PENS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Percutaneous electrical nerve stimulation (PENS).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Percutaneous electrical nerve stimulation (PENS).

**Decision rationale:** 4 Sessions of Percutaneous electrical nerve stimulator (PENS). Per the cited guidelines "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..." Therefore there is no high grade scientific evidence to support PENS for this diagnosis. Per the CA MTUS chronic pain guidelines, Percutaneous electrical nerve stimulation (PENS) is "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. (Ghonaime-JAMA, 1999) (Yokoyama, 2004).....PENS is generally reserved for patients who fail to get pain relief from TENS, apparently due to obvious physical barriers to the conduction of the electrical stimulation (e.g., scar tissue, obesity)..." Details regarding failure or contraindication of previous conservative therapy including physical therapy, TENS and pharmacotherapy are not specified in the records provided. The medical necessity of 4 Sessions of Percutaneous electrical nerve stimulator (PENS) is not fully established for this patient.