MAXIMUS Federal Services

Case Number:	CM15-0216195		
Date Assigned:	11/05/2015	Date of Injury:	10/26/1999
Decision Date:	12/24/2015	UR Denial Date:	10/30/2015
Priority:	Standard	Application Received:	11/03/2015

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, Hawaii
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 46 year old female who sustained an industrial injury on 10-26-99. A review of the medical records indicates she is undergoing treatment for rheumatism, cervical disc disorder with radiculopathy - mid cervical region, post-laminectomy syndrome, lumbago with sciatica - right side, sacroiliitis, and chronic pain syndrome. Medical records (4-15-15, 5-13-15, 6-13-15, and 9-30-15) indicate ongoing complaints of neck, right shoulder, bilateral knee, and low back pain. She rates her neck pain as "10 out of 10" with spasms on the right side of her neck. She rates her back pain as "12 out of 10" and reports numbness and tingling in the right leg. She reports "moderate" knee swelling and has noted right foot drop, right foot bone spurs, and fibromyalgia. She reports that she has the sensation of "ants crawling in her left ear" (9-30-15). The physical exam (9-30-15) reveals paralumbar spasm with "2+" tenderness to palpation on the right side. "Severe" pain is noted on palpation over the bilateral sacroiliac joints, which the provider indicates is "consistent with sacroiliits". Atrophy is present in the quadriceps. Diminished lumbar range of motion is noted. The straight leg raise is positive on the right at 40 degrees. Lower extremity deep tendon reflexes are absent at the knees. Sensation is diminished bilaterally of the lower extremities. Motor strength is noted to be "5 out of 5" of all groups in the bilateral lower extremities. Tenderness is noted along the lateral joint line of the left knee. Diminished range of motion is noted. The spine inspection reveals "asymmetry of the neck and shoulders, with tilting of the head and neck to the left". Left trapezius tenderness is noted. Range of motion is noted to be restricted. Diagnostic studies have included an MRI of the lumbar spine. Treatment has included oral and topical medications, physical therapy, and a

home exercise program. Treatment recommendations include continuation of medications, a cervical steroid epidural injection at C4 with IV sedation, and PENS treatment - 4 sessions to decrease chronic pain, use of opiates, and to help with the symptoms of ants crawling in her ear. The utilization review (10-30-15) includes a request for authorization of a percutaneous electrical nerve stimulator (neurostimulator). The request was denied.

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) (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 Chronic Pain Medical Treatment 2009, Section(s): Percutaneous electrical nerve stimulation (PENS).

Decision rationale: The patient presents with low back, neck, bilateral knee and right shoulder pain. The current request is for Percutaneous electrical nerve stimulator. The treating physician's report dated states, "Please authorize PENS treatment, 4 sessions. This way we could attempt to decrease this patient's chronic pain and decrease her opiates. Percutaneous Electrical Nerve Stimulator Treatment (PENS): I believe that treatment utilizing a neurostimulator is medically necessary and provides the best chance of affecting improvement for the patient. I recommend four separate treatments, over the course of 30 days, of percutaneous electrical stimulation of targeted peripheral nerves in an effort to reduce the patient's pain level, decrease medication consumption, reduce overall inflammation and improve functional levels." The patient has trialed and failed multiple conservative, non-surgical modalities such as; transcutaneous electrical nerve stimulator (TENS,) physical therapy/therapeutic exercises, pharmacological therapy, including oral and compounded medications, all have proven unsuccessful in controlling pain adequately. Medical records do show any previous PENS use. The MTUS Guidelines page 97 on percutaneous electrical nerve stimulation states that it is not recommended as a primary treatment modality, but a trial may be considered if used as an adjunct to a program of evidenced-based functional restoration or after nonsurgical treatments including therapeutic exercises and TENS have been tried and failed or judged to be unsuitable or contraindicated. PNS is generally reserved for patients who failed TENS due to obvious physical barriers to the conduction of electrical stimulation. In this case, the MTUS guidelines require a trial of PENS before a purchase can be considered to determine its efficacy in terms of pain relief and functional improvement. The current request is not medically necessary.