

Case Number:	CM15-0217169		
Date Assigned:	11/06/2015	Date of Injury:	05/06/2010
Decision Date:	12/22/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	11/04/2015

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:

This 58 year old male sustained an industrial injury on 6-5-10. Documentation indicated that the injured worker was receiving treatment for incomplete rotator cuff tear, acromioclavicular joint arthritis, left shoulder bicipital tendinitis, left shoulder impingement and left shoulder adhesive capsulitis. Previous treatment included left shoulder arthroscopy (2010), physical therapy, transcutaneous electrical nerve stimulator unit, injections and medications. The injured worker had been recommended for left shoulder surgery in March 2015 but had been unable to schedule the procedure. In a PR-2 dated 9-17-15, the injured worker complained of ongoing left shoulder and low back pain, rated 9 out of 10 on the visual analog scale. Physical exam was remarkable for tenderness to palpation to the cervical spine and cervical facets with "decreased" range of motion. Left upper extremity exam was declined due to pain. The treatment plan included four percutaneous electrical nerve stimulator treatments, increasing Gabapentin, discontinuing Ketoprofen, starting Meloxicam and Protonic, refilling Norco and continuing home exercise. On 10-20-15, Utilization Review noncertified a request for percutaneous electrical nerve stimulator x 4 separate treatments.

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 x4 separate treatment: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, under Percutaneous Electrical Nerve Stimulation.

Decision rationale: The patient presents on 09/17/15 with left shoulder and lower back pain rated 8/10 with medications, 9/10 without medications. The patient's date of injury is 06/05/10. The request is for percutaneous electrical nerve stimulator neurostimulator x4 separate treatment. The RFA was not provided. Physical examination dated 09/17/15 reveals tenderness to palpation of the cervical spine and paraspinal musculature, cervical facet tenderness from C5-T1 levels, and pain elicitation with right lateral bending and rotation. The patient is currently prescribed Gabapentin, Ketoprofen, Protonix, Meloxicam, and Norco. Per work status report dated 10/13/15, the patient is "unable to work." 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." Official Disability Guidelines, Low Back Chapter, under Percutaneous Electrical Nerve Stimulation (PENS) has the following: 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. Lack of high quality evidence to prove long-term efficacy in the treatment of acute low back symptoms. A recent small clinical trial suggests that PENS may be a promising treatment modality for community-dwelling older adults with chronic low back pain. However, successful outcomes are dependent on technique. PENS is an invasive modality, provided by a skilled operator, utilizing needles to deliver a direct current to muscle tissue. This RCT concluded that both PENS and therapeutic exercise for older adults with chronic low back pain significantly reduced pain. In regard to the request for a series of 4 PENS treatments for this patient's ongoing lumbar spine complaint, such treatments are not supported as a standalone measure. While this patient presents with chronic lower back pain unresolved by conservative measures to date, ODG guidelines do not support this treatment in isolation but as an adjunct to an evidence based functional restoration program. The current request does not appear to be in the context of a functional restoration program and therefore does not meet guideline requirements. The request is not medically necessary.

Durable medical equipment MI: Upheld

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

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

Decision rationale: The patient presents on 09/17/15 with left shoulder and lower back pain rated 8/10 with medications, 9/10 without medications. The patient's date of injury is 06/05/10. The request is for durable medical equipment MI. The RFA was not provided. Physical examination dated 09/17/15 reveals tenderness to palpation of the cervical spine and paraspinal musculature, cervical facet tenderness from C5-T1 levels, and pain elicitation with right lateral bending and rotation. The patient is currently prescribed Gabapentin, Ketoprofen, Protonix, Meloxicam, and Norco. Per work status report dated 10/13/15, the patient is "unable to work." Official Disability Guidelines, Knee and Leg Chapter, under Durable Medical Equipment (DME) has the following: Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. In regard to the unspecified durable medical equipment, treater has not provided a reason for the request or a description of the item in question. This patient's medical documentation does not lend any insight into the exact nature of the requested DME, as the RFA was not provided, there is no discussion of the device in the most recent progress reports, and the utilization review denial does not address the request. As no description of the DME is provided, it is impossible to determine whether it is primarily and customarily used to serve a medical purpose. Without a clearer picture of the true nature of the requested medical device, compliance with ODG/MTUS guidelines cannot be established. Therefore, the request is not medically necessary.