

<b>Case Number:</b>	CM15-0224810		
<b>Date Assigned:</b>	11/23/2015	<b>Date of Injury:</b>	03/23/2015
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/16/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 49-year-old male, who sustained an industrial injury on 3-23-2015. Diagnoses include left peritrochanteric hip fracture, status post open reduction internal fixation (ORIF) on 3-23-15, with subsequent left peroneal deep vein thrombosis (DVT), and left sciatic nerve neurapraxia. Treatments to date include activity modification, physical therapy, and medication therapy including anti-coagulation therapy and narcotic. On 8-25-15, he complained of ongoing left lower extremity pain and weakness, although the records do documented some reported improvement in ambulation and range of motion. Pain levels were down to 2 out of 10 VAS. The physical examination documented "the sciatic nerve neuropraxia continues to resolve." The plan of care included additional physical therapy sessions combined with home exercise. At re-evaluation on 10-6-15, he rated pain 3-4 out of 10 VAS and reported he was improving with therapy. The physical examination documented no changes. The plan of care included a prescription for Norco 10-325mg and a TENS unit. The appeal requested authorization for hydrodissection of sciatic nerve and a TENS unit. The Utilization Review dated 10-13-15, denied the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrodissection of sciatic nerve:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Neuromuscular electrical stimulation (NMES devices) and Other Medical Treatment Guidelines AANEM Recommended Policy for Electrodiagnostic Medicine.

**Decision rationale:** The claimant sustained a work injury in March 2015 when, while riding a motorcycle, he was hit by a car. He sustained a peritrochanteric hip fracture with left sciatic nerve neurapraxic injury. He underwent ORIF and his postoperative course was complicated by DVT. He has been receiving postoperative physical therapy and from April 2015 through 10/05/15, he completed 64 treatment sessions. He had increased left lower extremity strength but remained unable to dorsiflex his left foot and was continuing to wear a brace. When seen in October 2015 he had pain rated at 3-4/10. There had been mild improvement in sensation. Physical examination findings were consistent with the previous examination, which demonstrated decreased hip flexion and abduction strength and 1-/5 ankle dorsiflexion strength. Neuromuscular electrical stimulation (NMES) devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range of motion, and re-educate muscles. It can be recommended as an option only for short-term use during rehabilitation early in the postoperative period following major knee surgeries. Use of a neuromuscular electrical stimulation (NMES) device for the treatment of pain is not recommended. In this case, the claimant underwent surgery more than 6 months ago. Electrodiagnostic testing would be helpful in determining the extent of his injury and prognosis for recovery. Recovery from a purely neurapraxic injury would be expected to have occurred by now suggesting the presence of axonal or nerve disruption. If he sustained an axonal injury, electrical stimulation would be relatively contraindicated. Without the results of a recent electrodiagnostic evaluation, a NMES stimulator cannot be accepted as being medically necessary. In terms of TENS, a one-month home-based trial may be considered as a noninvasive conservative option. Criteria for the continued use of TENS include documentation of a one-month trial period of the TENS unit including how often the unit was used, as well as outcomes in terms of pain relief. In this case, there is no documented home-based trial of a basic TENS unit. The requested combination unit is not medically necessary.

**NMES/TENS Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (1) AANEM Recommended Policy for Electrodiagnostic Medicine (2) Sunderland S: The anatomy and physiology of nerve injury. Muscle Nerve 13:771- 784, 1990.

**Decision rationale:** The claimant sustained a work injury in March 2015 when, while riding a motorcycle, he was hit by a car. He sustained a peritrochanteric hip fracture with left sciatic nerve neurapraxic injury. He underwent ORIF and his postoperative course was complicated by DVT. He has been receiving postoperative physical therapy and from April 2015 through 10/05/15, he completed 64 treatment sessions. He had increased left lower extremity strength but remained unable to dorsiflex his left foot and was continuing to wear a brace. When seen in October 2015 he had pain rated at 3-4/10. There had been mild improvement in sensation. Physical examination findings were consistent with the previous examination, which demonstrated decreased hip flexion and abduction strength and 1-/5 ankle dorsiflexion strength. In terms of the requested sciatic nerve dissection procedure, electrodiagnostic testing would be indicated to determine the extent of his injury and prognosis for recovery. Performing a neurolysis procedure without the results of a recent electrodiagnostic evaluation showing conduction block and without evidence of a failure of spontaneous recovery cannot be accepted as being medically necessary.