

Case Number:	CM14-0183209		
Date Assigned:	11/10/2014	Date of Injury:	12/07/2001
Decision Date:	12/15/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	11/04/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54-year-old male who reported an injury on 12/07/2001 due to getting out of his car and standing upright. His diagnoses include status post posterior spinal fusion at L2-3 and L3-4, status post right and left total hip replacement, gastritis, chronic pain syndrome, chronic severe low back pain, bilateral lower extremity neuropathic pain, lumbar spine local neuropathic pain, bilateral sacroiliitis, status post right knee arthroscopy, and status post left knee arthroscopy. His past treatments include aquatic therapy, physical therapy, and modified activities. The diagnostic studies were noted to include an EMG/NCV of the bilateral lower extremities performed on 07/10/2010 which revealed EMG findings suggestive of active and chronic irritation of the bilateral lumbar paraspinal soft tissues and evidence of pre-existing left S1 radiculopathy without evidence of ongoing denervation. Additionally, the NCV revealed findings consistent with pre-existing L5-S1 radiculopathies. An MRI of the right hip performed on 04/14/2009 revealed avascular necrosis of the right femoral head and an MRI of the left hip performed on 10/29/2007 revealed stage IV avascular necrosis of the femoral head. A bone scan imaging study of the left and right hips was completed on 01/31/2014 and revealed left hip abnormal osteoblastic reaction around the acetabular component area of the left proximal femur prosthesis and there was no abnormal reaction around the proximal right femur prosthesis. His surgical history includes a total right hip replacement on 10/21/2010 and a total left hip replacement on 02/21/2008. He also underwent a spinal fusion at L2-3 and L3-4 on 08/24/2011. On 03/21/2014, the injured worker reported constant increasing low back pain of 9/10 with radiation to the bilateral lower extremities down into his feet as well as numbness and tingling. He also had complaints of bilateral hip pain of 9/10 and right knee pain of 9/10. The objective findings revealed restricted range of motion in the lumbar spine, bilaterally positive straight leg raise and decreased motor strength in the bilateral hip flexor and quadriceps. His current

medications were noted to include Percocet, fentanyl patch, Lyrica, Cymbalta, and Ambien. The treatment plan included continuation of previously prescribed medications and a discussion of treatment options. A request was received for 4 treatments of percutaneous electrical nerve stimulation. A rationale was not provided. A Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

(4) Treatments of Percutaneous Electrical Nerve Stimulator (Neurostimulator): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS Page(s): 97.

Decision rationale: The request for (4) Treatments of Percutaneous Electrical Nerve Stimulator (Neurostimulator) is not medically necessary. The California MTUS Guidelines recommend a trial of percutaneous electrical nerve stimulation (PENS) when used as an adjunct to an evidence-based functional restoration program, after other nonsurgical treatments, including therapeutic exercise and TENS, have been tried and failed or judged to be unsuitable or contraindicated. There was insufficient documentation to show conservative treatments received since 01/2001, evidence of a functional restoration program that will be used in conjunction to the PENS unit, evidence of failed conservative treatments or documentation to show that previous conservative therapies were found unsuitable or contraindicated. Additionally, there were no exceptional factors to significantly demonstrate the necessity of a PENS unit at this time. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for (4) Treatments of Percutaneous Electrical Nerve Stimulator (Neurostimulator) is not medically necessary.