MAXIMUS Federal Services

Case Number:	CM15-0116245		
Date Assigned:	06/24/2015	Date of Injury:	01/18/2010
Decision Date:	07/29/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/16/2015

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: 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 47 year old male patient, who sustained an industrial injury on 1/18/10. The diagnoses have included sacroiliitis of left sacroiliac joint. Per the doctor's note dated 5/6/2015, he had complaints of pain over left buttock radiating to posterior and lateral aspect of left thigh with numbness and tingling progressively increasing in severity. He had also complaints of low back pain with left leg tingling and numbness. The physical examination revealed limited lumbar spine range of motion, positive Gaenslen's and Patrick Fabre test and positive sacroiliac joint thrush. The medications list includes gabapentin, celebrex and topical compound cream. He has had magnetic resonance imaging (MRI) of the lumbar spine on 1/28/15 which showed L5/S1 (sacroiliac) mild broad left eccentric disc protrusion with a posterior annular tear. He has had transcutaneous electrical nerve stimulation unit and injections for this injury. The request is for 4 implantation of percutaneous neurostimulators.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 Implantation of Percutaneous Neurostimulators: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines page 97 Percutaneous electrical nerve stimulation (PENS).

Decision rationale: 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. In addition 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. (Ghoname-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)..." Failure of previous conservative therapy including TENS, physical therapy and pharmacotherapy is not specified in the records provided. The request for 4 Implantation of Percutaneous Neurostimulators is not medically necessary or fully established for this patient.