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**Notice of Independent Medical Review Determination**

Dated: 10/11/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	7/21/2008
IMR Application Received:	7/22/2013
MAXIMUS Case Number:	CM13-0002372

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 placement of percutaneous neurostimulator motor unit and implantation of the leads **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 placement of percutaneous neurostimulator motor unit and implantation of the leads **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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 treatments and/or services at issue.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013:

“The patient is a 52-year-old female who injured her right knee on 7/21/08 when she fainted and fell (due to a trip-and-fall incident as per nurse's clinical summary). She is diagnosed with right lower leg CRPS type II. A request for placement of percutaneous neurostimulator motor unit and implantation of the leads is made. The patient re-injured her right knee on 8/7/08 when she tripped (n) a high curb and hit her knee. She had been evaluated with x-rays (2008) and MR is (2008). Of note, she started having low back pain between 12/2009 and 6/2010 secondary to lifting heavy parts. She reportedly had an MRI which demonstrated a 2 mm disc protrusion with no evidence of frank herniation. She was noted to have reactive depression and anxiety as well as sleep problems from ongoing pain and loss of functioning. She underwent two surgeries to the right knee including arthroscopy and partial meniscectomy on 2/5/09 (as per 1/12/13 report), and unicompartmental knee replacement on 6/28/10. Other treatments had included pain medications, massage, muscle stimulation, Physical Therapy (2008, 2009 and 2010), self-exercises, psychotherapy, biofeedback (2012), psychiatric medications, cortisone injections, viscosupplementation, and use of cane and knee brace. She had been recommended for conversion from a unicompartmental to a total knee replacement. The 7/19/12 and 8/2/12 –reports by the referring provider indicated a diagnosis -of CRPS type II of the right lower extremity. At that time, she was documented with significant allodynia of the right knee with fusiform swelling. Sympathetic blocks were recommended, but there was no indication that-these-had been performed. As per 9/17/12 qualified medical re-evaluation, her history reportedly did not fit the classical-picture of CRPS and her findings on examination were

inconclusive: The examiner did not document the skin pseudomotor-changes previously described by the treating physician. As per 6/13/13 progress-report, she was using Norco three tablets a day and compounded creams including ketoprofen, tramadol, gabapentin and cyclobenzaprine. She was also taking mexiletine 150 mg two to three times a day for neuropathic pain. As per 6/25/13 report, she was noted to have +2 synovitis. She was again recommended conversion to a total knee replacement. The 6/26/13 letter of medical necessity indicated a request for percutaneous electrical stimulation treatment over a four-day period to reduce the patient's pain levels, decrease narcotic consumption, reduce overall inflammation, reduce sympathetic stimulation, and improve functional levels. The requesting provider cited guidelines and studies on peripheral electrical nerve stimulation. (PENS). PENS is a therapy that combines the features of electroacupuncture and transcutaneous electrical nerve stimulation (TENS). It employs fine needle-like electrodes that are placed in close proximity to the painful area and stimulate peripheral sensory nerves in the soft tissue. The DWC authorization request form indicated a request for a neurostimulator with CPT-code 64555 for percutaneous implantation of neurostimulator electrodes. Clarification is needed regarding the actual neurostimulator being requested as PENS generally-does not involve implantation of leads (as seen in SCS placement). This patient is indicated to have neuropathic pain secondary to CRPS. She had been documented with allodynia-and swelling of the right knee about a year ago, but these findings were reportedly not evident in the 9/7/12 qualified medical re-evaluation. An updated examination showing current findings consistent with CRPS for which the requested neurostimulator unit is indicated has not been provided in the latest records. Lastly, there is no indication that the patient has had an adequate trial of TENS with insufficient pain relief. With the above issues, the medical necessity of this request is undetermined at this time.”

#### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (received 07/22/2013)
- Utilization Review Determination from [REDACTED] (dated 07/09/2013)
- Employee Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule(MTUS)

#### **1) Regarding the request for 1 placement of percutaneous neurostimulator motor unit and implantation of the leads :**

##### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), PENS section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a work related injury on July 21, 2008 resulting in right lower leg CRPS type 2. Treatments have included knee surgeries, pain medications, massage, muscle stimulation, physical therapy, self-exercises, psychotherapy, biofeedback, psychiatric medications, cortisone injections, viscosupplementation, percutaneous electrical stimulation treatments and use of cane and knee brace. The request is for 1 placement of percutaneous neurostimulator motor unit of the leads.

The MTUS Chronic Pain Guideline recommends a trial of percutaneous electrical nerve stimulation (PENS) if it is used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and transcutaneous electrical nerve stimulation (TENS), have been tried and failed. There is no indication that the patient has failed the TENS therapy. There is no mention of the PENS therapy being used as an adjunct to a program of evidence-based functional restoration. Guideline criteria are not met. The request for 1 placement of percutaneous neurostimulator motor unit of the leads **is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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