

Case Number:	CM13-0024483		
Date Assigned:	11/20/2013	Date of Injury:	05/26/2011
Decision Date:	02/06/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	09/13/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Cardiology and is licensed to practice in Texas. 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 physician 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 patient is a 55-year-old male who sustained a work related injury on 05/26/2011. The patient's diagnoses include lateral epicondylitis, skin sensation disturbance, depressive disorder, anxiety, and reflex sympathetic dystrophy of the upper limb. In the clinical information submitted for review, the patient was noted to have reported complaints of persistent right elbow pain consistent with lateral epicondylitis with failed lower levels of conservative care, and subsequently underwent right elbow arthroscopy, right elbow lateral epicondylectomy, and extensor conjoint-tendon tenolysis and decompression on 09/06/2013. The patient's most recent evaluation performed on 09/23/2013 documented wrist pain of 8/10 which was managed with Trazodone, MS Contin, MSIR, and Desipramine. Physical examination revealed decreased range of motion to the right shoulder and elbow, a well-healed surgical scar in the right elbow, and mild erythema over the right arm. The treatment plan consisted of a right upper extremity EMG, medication refills, continuation of activities, and a percutaneous peripheral nerve stimulator for the right upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient percutaneous peripheral nerve stimulator for the right upper extremity:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines, "<http://www.odg-twc.com/odgtwc/pain.htm#Functionalimprovementmeasures>".

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

Decision rationale: The requested outpatient percutaneous peripheral nerve stimulator for the right upper extremity is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has significant pain complaints of the right upper extremity. California Medical Treatment Utilization Schedule recommends this treatment modality as an adjunct therapy for an evidence based functional restoration program after other non-surgical treatments have failed to provide significant symptom relief. The clinical documentation submitted for review does not provide any evidence that the patient is participating in an active therapy program that would benefit from the adjunct therapy of a percutaneous electrical nerve stimulator. Additionally, there is no documentation that the patient's pain has failed to respond to a TENS unit. As such, the requested percutaneous electrical nerve stimulator is not considered medically necessary or appropriate.