

Case Number:	CM14-0078697		
Date Assigned:	07/21/2014	Date of Injury:	01/30/2012
Decision Date:	08/29/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/29/2014

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 Occupational Medicine 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 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:

According to the records made available for review, this is a 34-year-old female with a 1/30/12 date of injury. At the time (5/6/14) of request for authorization for percutaneous electrical nerve stimulation (Neurostimulator), there is documentation of subjective (right wrist/upper extremity pain with discoloration, swelling, sensitivity and the hand remains cold) and objective (right upper extremity discoloration, right hand is cold, intermittent tremor, twitching, and profound allodynia in the right hand and forearm) findings, current diagnoses (right upper extremity complex regional pain syndrome with upper extremity ankylosis), and treatment to date (stellate ganglion block, physical therapy, wrist support, wrist cortisone injection, TENS, and medications). There is no documentation that the request is intended for a trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percutaneous Electrical Nerve Stimulation (Neurostimulator): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 97.

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that percutaneous electrical nerve stimulation is to be 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, as criteria necessary to support the medical necessity of a trial of percutaneous electrical nerve stimulation. Within the medical information available for review, there is documentation of diagnoses of right upper extremity complex regional pain syndrome with upper extremity ankylosis. In addition, there is documentation of non-surgical treatments (including therapeutic exercise and TENS) and that percutaneous electrical nerve stimulation is to be used as an adjunct to a program of evidence-based functional restoration. However, there is no documentation that the requested is intended for a trial. Therefore, based on guidelines and a review of the evidence, the request for percutaneous electrical nerve stimulation (Neurostimulator) is not medically necessary.