

Case Number:	CM15-0187087		
Date Assigned:	09/29/2015	Date of Injury:	07/06/2009
Decision Date:	11/10/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/23/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 39 year old male, who sustained an industrial injury on 7-6-2009. The injured worker was being treated for mononeuritis of the upper extremity, shoulder pain, fasciitis, and chronic pain syndrome. Medical records (6-1-2015 to 9-9-2015) indicate ongoing right shoulder pain, which is sharp and stabbing at times. The injured worker reported that lifting objects increased his pain. The medical records show the subjective pain rating shows no significant improvement from 8 out of 10 on 6-1-2015 to 7 out of 10 with medication and 8-9 without medications on 9-9-2015. The physical exam (6-1-2015 to 8-31-2015) revealed tenderness to palpation, flexion of 160 degrees, abduction of 110 degrees, full internal rotation, limited external rotation, and strength of 4 out of 5 of the right shoulder. The physical exam (9-9-2015) revealed limited range of motion of the right shoulder due to pain. Per the treating physician (4-20-2015 report), an MRI of the right shoulder revealed moderate recurrent or residual supraspinatus tendinosis without evidence for a through and through tear. There were interstitial and anterior articular surface foci of delamination affect less than 50% of the cross section area of the tendon. In addition, findings included status post acromioplasty-Mumford procedure. The medical records show that the injured worker underwent 4 Neurostimulator treatments between 8-5-2015 and 8-26-2015, with decreased use of Hydrocodone, Norflex, and Flexeril. Other treatment has included physical therapy, aquatic therapy, transcutaneous electrical nerve stimulation (TENS), heat, cold, cortisone injections, and medications including pain, topical pain, muscle relaxant, and non-steroidal anti-inflammatory. Per the treating physician (9-9-2015 report), the prior percutaneous electrical nerve stimulation

(Neurostimulator) treatments resulted in decreased and-or changed the injured worker's pain medications, significant sleep improvement, mood enhancement, decreased depression, increased energy, and restoration of overall functional improvement. Per the treating physician (9-9-2015 report), the employee has not returned to work. On 9-9-2015, the requested treatments included 4 treatments of percutaneous electrical nerve stimulation (Neurostimulator) for the right shoulder. On 9-16-2015, the original utilization review non-certified/modified a request for Norco 10/325 #30 (original request for #150) to allow for weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) percutaneous electrical nerve stimulation (Neurostimulator) x 4 treatments for the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Percutaneous electrical nerve stimulation (PENS).

Decision rationale: The claimant sustained a work injury to the right shoulder in July 2009 while repairing a phone line in a residential crawlspace. He underwent arthroscopic surgery. When seen, he was having right shoulder pain. He had pain rated at 7/10 with medications. Physical examination findings included decreased and painful shoulder range of motion. The assessment references failure of multiple conservative therapies including physical therapy, NSAID medication, TENS, and medications. He had previously undergone four PENS treatments with the last completed on 08/26/15. Authorization for an additional four treatments is being requested. 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. In this case, the claimant has already had four PENS treated without functional improvement. No adjunctive treatments are being provided. The request is not medically necessary.