

<b>Case Number:</b>	CM15-0048381		
<b>Date Assigned:</b>	03/20/2015	<b>Date of Injury:</b>	01/17/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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: New Jersey  
 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:

The injured worker is a 57 year old male, who sustained an industrial injury on 1/17/14. He reported left hand problems. The injured worker was diagnosed as having superficial radial neuralgia, left median neuralgia and status post left hand surgery. Treatment to date has included x-rays, (MRI) magnetic resonance imaging, upper extremity Electrodiagnostic studies, left hand surgery, physical therapy and oral medications. Currently, the injured worker complains of left hand pain, left knee pain, right thigh pain and left thigh pain. Physical exam noted a weakness to grasp on left, jagged scar across base of left thumb with hypoesthesia and allodynia proximal to the scar. The treatment plan consisted of Percutaneous Electrical Neurostimulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percutaneous electrical nerve stimulation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), PENS.

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

**Decision rationale:** Percutaneous electrical nerve stimulation, according to the MTUS Chronic Pain Treatment Guidelines, is not recommended as a primary treatment modality, but a trial (1 month duration) 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. 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). In the case of this worker, there was insufficient evidence presented in the notes provided for review to show the worker tried and failed TENS or that there was a home exercise program to be combined with the PENS. Therefore, considering the above, this request for percutaneous electrical nerve stimulation does not appear to be medically necessary at this time.