

Case Number:	CM14-0160516		
Date Assigned:	10/06/2014	Date of Injury:	11/11/2005
Decision Date:	10/30/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	09/30/2014

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 Family Medicine and is licensed to practice in Arizona. 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:

Patient is a 49 year old male with a date of injury on 11/11/2005. The patient underwent cubital tunnel release in 2009, ulnar nerve transposition in 2010, and left shoulder arthroscopic surgery in 2013. Subjective complaints are of neck pain, bilateral shoulder pain, low back pain, headaches, and depression. Physical exam shows an antalgic gait, cervical muscle guarding and tenderness, decreased range of motion, and positive axial compression test. The bilateral shoulders have diffuse subacromial tenderness with decreased range of motion. There is left medial epicondyle tenderness, and bilateral wrist tenderness. The lumbar spine has diffuse muscle guarding and tenderness, and a positive bilateral straight leg raise test. Prior treatment has included TENS, physical therapy, and medications. Request is for percutaneous peripheral nerve stimulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percutaneous electrical nerve stimulator treatment: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PERCUTANEOUS NERVE STIMULATION Page(s): 97.

Decision rationale: CA MTUS does not recommend percutaneous electrical nerve stimulation (PENS), but a trial may be considered, if used as an adjunct to a program of restoration, after other non-surgical treatments have been tried and failed. For this patient, other conservative treatments including physical therapy and TENS have not been efficacious. Therefore, the request for a trial of PENS is consistent with guideline recommendations, and the medical necessity is established.