MAXIMUS Federal Services

Case Number:	CM15-0012103		
Date Assigned:	01/29/2015	Date of Injury:	01/22/2014
Decision Date:	03/25/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	01/21/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 34 year old female sustained an industrial injury on 1/22/14 with subsequent ongoing left wrist and upper extremity pain. In an office visit dated 12/9/14, the injured worker complained of pain to the left wrist and bilateral upper extremities, 7-8/10 on the visual analog scale. Physical exam was remarkable for decreased sensation to left fourth and fifth digits and medial forearm, weakness to grip and first to fifth digit opposition, decreased deep tendon reflexes and tenderness to palpation in the subacromial left shoulder and subacromial-subdeltoid bursa. No radiologic studies were available for review. Current diagnoses included chronic pain syndrome, peripheral neuropathy, hand pain, shoulder pain and fasciitis. The physician noted that the injured worker had failed conservative therapy including physical therapy, TENs and medications. The treatment plan included medications (Gabapentin, Mobic, Omeprazole and topical compound cream, requesting authorization for upper extremity EMG/NCV, continuing muscle strengthening and consider Neurostimulator Treatment (four treatments over 30 days).On 1/13/15, Utilization Review modified a request for 4 treatments for 4 consecutive weeks percutaneous electrical nerve stimulator (Neurostimulator) x 4 units (purchase) to 4 treatments for 4 consecutive weeks percutaneous electrical nerve stimulator (Neurostimulator) x 4 units (trial) citing CA MTUS Chronic Pain Medical Treatment Guidelines As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 treatments for 4 consecutive weeks percutaneous electrical nerve stimulator (Neurostimulator) x 4 units (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation pain chapter, under PENS

Decision rationale: The patient presents with pain, rated 7-8/10, to the left wrist and bilateral upper extremities. The request is for 4 TREATMENTS FOR 4 CONSECUTIVE WEEKS PERCUTANEOUS ELECTRICAL NERVE STIMULATOR NEUROTRANSMULATOR X4 UNITS (PURCHASE). The RFA is not provided. Patient's diagnosis included chronic pain syndrome, peripheral neuropathy, hand pain, shoulder pain and fasciitis. Patient is temporality totally disabled. For PENS unit, ACOEM guidelines page 300 states: 'Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy.'ODG guidelines pain chapter, under PENS, '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. There is a lack of high quality evidence to prove long-term efficacy. 'In this case, the patient has failed multiple other treatment modalities, including TENS. ODG guidelines, however, do not support this treatment in isolation but as an adjunct to a program functional restoration. The current request does not appear to be in the context of a functional restoration program. The request IS NOT medically necessary.