

<b>Case Number:</b>	CM15-0016446		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	12/02/2010
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	01/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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: Emergency Medicine

### 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 12/2/10. The injured worker has complaints of upper extremity pain. The diagnoses have included chronic pain syndrome and cervical radiculopathy. Only documentation provided is a letter requesting services with statement claiming that the injured worker has trialed and failed multiple conservative, non-surgical modalities such as transcutaneous electrical nerve stimulator, physical therapy/therapeutic exercises, pharmacological therapy, including oral and compounded medications, all have proven unsuccessful in controlling pain adequately however no details of what medications or other conservative attempts were attempted. Progress note provided dated 12/11/14 is very poor and only documents "pain to L side; constant; "not legible" buttocks" and objective exam only notes tenderness and no other findings were documented. No medication list was provided. Only note was Zomig and Tramadol. No imaging or electrodiagnostic studies were provided for review. According to the utilization review performed on 1/22/15, the requested Percutaneous electrical nerve stimulator (neurostimulator) series of four (4) separate neurostimulator treatments over the course of thirty (30) days has been non-certified. CA MTUS Chronic Pain Medical Treatment Guidelines percutaneous electrical nerve stimulation was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percutaneous electrical nerve stimulator (neurostimulator) series of four (4) separate neurostimulator treatments over the course of thirty (30) days: Upheld**

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

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

**Decision rationale:** As per MTUS Chronic pain guidelines, Percutaneous Electrical Nerve Stimulation(PENS) may be considered as part of a Functional Restoration Program after failure of other conservative modalities especially standard Transcutaneous Electrical Nerve Stimulation(TENS), standard therapy or exercise have failed. It requires a trial before full treatments are recommended. Documentation provided is very poor. There is only vague claim of treatment failure but no current or prior medication list was provided, no prior treatment modalities were documented, documentation of TENS failure or documentation of active functional restoration program. Provided documentation does not support the use of PENS therefore it is not medically necessary.