

<b>Case Number:</b>	CM15-0129521		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	10/12/1999
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 60-year-old male who sustained an industrial injury on 10/12/99. Initial complaints and diagnoses are not available. Treatments to date include back surgery, left hand surgery, a right shoulder injections, and medications. Diagnostic studies are not addressed. Current complaints include pain in the lower back. Current diagnoses include degeneration of cervical and lumbar intervertebral discs, cervical and lumbar disc displacement, cervical radiculitis, lumbar radiculopathy, post laminectomy syndrome, low back pain, shoulder impingement, and chronic pain syndrome. In a progress note dated 06/10/15 the treating provider reports the plan of care as refill medications, 4 sessions of Percutaneous Electrical Nerve stimulation treatments, and orthopedic consultation for his right shoulder. The requested treatment includes 4 sessions of Percutaneous Electrical Nerve stimulation treatments.

### 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), 4 separate treatments:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

**Decision rationale:** According to MUTUS guidelines, PENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this patient. Furthermore, there is no efficacy of previous use of TENS. There is no recent documentation of recent flare of the patient pain. The provider should document how PENS will improve the functional status and the patient's pain condition. Therefore, the prescription of Percutaneous electrical nerve stimulator (neurostimulator), 4 separate treatments is not medically necessary.