

<b>Case Number:</b>	CM15-0096883		
<b>Date Assigned:</b>	05/27/2015	<b>Date of Injury:</b>	03/16/2001
<b>Decision Date:</b>	07/01/2015	<b>UR Denial Date:</b>	04/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### 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 is a 55-year-old female with a March 16, 2001 date of injury. A progress note dated January 15, 2015 documents subjective findings (excruciating and debilitating headaches which turn into migraines and are associated with photophobia, nausea, and vomiting; headaches occur more than fifteen days over the previous two months and last for up to four to five hours per day), objective findings (guarding of upper extremities; notable hypersensitivity in the entire upper extremities; tremors in upper and lower extremities; significant point tenderness and trigger points noted in the lumbar musculature and parathoracic musculature), and current diagnoses bilateral upper and lower extremity chronic regional pain syndrome; De Quervain's tenosynovitis; lateral epicondylitis; chronic cervicogenic headaches becoming migrainous). Treatments to date have included medications, Botulinum injections (significant pain relief), cervical and lumbar spinal cord stimulator, use of a motorized scooter, computed tomography scan of the lumbar spine (November 22, 2004; showed a mild degree of facet arthropathy), and electromyogram of the upper extremities (April 9, 2003; showed findings consistent with right ulnar motor neuropathy). The treating physician documented a plan of care that included percutaneous electrical nerve stimulator 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 (neruostimulator) x 4 separate treatments over a 30 day period:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Neck and Upper Back Chapter Percutaneous electrical nerve stimulation (PENS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, PENS.

**Decision rationale:** The 55 year old patient complains of severe headaches that transform into migraine, and has been diagnosed with bilateral upper extremity CRPS, bilateral lower extremity CRPS, De Quervain's tenosynovitis, lateral epicondylitis, multiple caries secondary to xerostomia due to opioid use, medication-induced gastritis, and chronic cervicogenic headaches, as per progress report dated 01/15/15. The request is for PERCUTANEOUS ELECTRICAL NERVE STIMULATOR (NEUROSTIMULATOR) X 4 SEPERATE TREATMENTS OVER A 30 DAY PERIOD. There is no RFA for this case, and the patient's date of injury is 03/16/01. The patient is status post multiple upper extremity SCS revisions with the most recent one being on 02/13/14 and status post multiple lower extremity SCS revisions with the most recent one being on 01/28/10, as per progress report 01/15/15. Medications included Ultracet, Prilosec, Oxycontin, Norco, Cymbalta, Wellbutrin, Flector patch, Neurontin, and Ativan. The reports do not document the patient's work status. For PENS unit, ACOEM guidelines page 300 states: "Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electricalneurostimulation (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, none of the progress reports do not discuss the request. The patient appears to be benefiting from other treatment modalities including medications and SCS. Additionally, ODG guidelines 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. Hence, the request IS NOT medically necessary.