

<b>Case Number:</b>	CM14-0083718		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	02/22/2012
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

The patient is a 52 year old male who was injured on 02/22/2012. The mechanism of injury is unknown. Progress report dated 05/02/2014 states the patient presented with right shoulder symptoms which are unchanged from previous visits. He has moderate to severe pain with limited range of motion and strength. He rated his pain as 6/10. On exam, right shoulder AROM revealed flexion 110; extension to 28; adduction to 32; adduction to 10; internal rotation to 62; external rotation to 71. He has decreased motor strength at 4-/5 and positive right shoulder impingement. He is diagnosed with bilateral wrist tendonitis. The patient was instructed to continue with home exercise program. The treatment plan listed below was requested on note dated 05/06/2014 which is not available for review. Prior utilization review dated 05/20/2014 states the requests for SurgiStim4 Rental with Supplies x90 days; CPM Rental x45 Days; Cold Therapy Unit (Purchase); and Shoulder Sling are denied as medical necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **SurgiStim4 Rental with Supplies x90 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neurovascular Electrical Stimulation (NMES) Devices.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-226, Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, TENS, NMES devices, ICS <http://www.vqorthocare.com/products/orthostim-4-surgistim-4/>

**Decision rationale:** This is a request for SurgiStim4 rental for 90 days with supplies for a 52-year-old male with plans for right shoulder subacromial decompression and distal clavicle resection. According to online search SurgiStim4 is a multimodal transcutaneous electrotherapy device that uses neuromuscular electrical stimulation and interferential current stimulation and perhaps TENS. However, MTUS guidelines do not recommend TENS for post-operative use. According to ODG guidelines, TENS for the shoulder is "recommended post-stroke to improve passive humeral lateral rotation, but there is limited evidence to determine if the treatment improves pain. (Price, 2000) For other shoulder conditions, TENS units are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapy providers available for referral." NMES devices are "under study for use with exercises to enhance the amount of force production and potentially minimize the inhibition of the rotator cuff after repair surgery." Interferential current stimulation is "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work and exercises, and limited evidence of improvement on those recommended treatments." In sum, transcutaneous electrotherapy is not recommended for post-operative treatment of shoulder decompression and distal clavicle resection by either MTUS or ODG guidelines. Medical necessity is not established.

**CPM Rental x45 Days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Continuous Passive Motion (CPM)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-226. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous passive motion (CPM)

**Decision rationale:** According to ODG guidelines, continuous passive motion (CPM) is "not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." MTUS guidelines recommend shoulder CPM only for adhesive capsulitis as well. In this case a request is made for CPM for post-operative treatment of right shoulder subacromial decompression and distal clavicle resection. Medical necessity is not established.

**Cold Therapy Unit (Purchase):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Continuous Flow Cryotherapy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-226. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow cryotherapy

**Decision rationale:** According to ODG guidelines, continuous-flow cryotherapy is "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." In this case a request is made for a cold therapy unit purchase for a 52-year-old male with plans for right shoulder subacromial decompression and distal clavicle resection. However, guidelines only recommend use up to 7 days after surgery such that the cold therapy units are typically rented. Medical necessity for purchase of a cold therapy unit is not established.

**Shoulder Sling:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Post-Operative sling/abduction pillow

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-226. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Postoperative abduction pillow sling

**Decision rationale:** According to MTUS guidelines, shoulder sling may be indicated for 1-2 days after acute injury. According to ODG guidelines, post-operative abduction sling is "recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs." In this case a request is made for a shoulder sling for a 52-year-old male with plans for right shoulder subacromial decompression and distal clavicle resection. However, there is no acute injury or planned rotator cuff repair. No detailed rationale is provided. Medical necessity is not established.