

<b>Case Number:</b>	CM15-0039154		
<b>Date Assigned:</b>	03/09/2015	<b>Date of Injury:</b>	11/09/2013
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	02/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/02/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 51-year-old female sustained an industrial injury to the right shoulder on 11/9/13. Injury occurred when she was lifting a sheet pan with 5 cakes on it. The 8/13/14 right shoulder MRI impression documented a full thickness rotator cuff tear with mild retraction but no significant atrophy, small glenohumeral joint effusion, mild biceps tenosynovitis, and subacromial findings consistent with impingement syndrome. There was evidence of a remote acromioclavicular (AC) ligament injury with moderate AC osteoarthritis. On 1/29/15, the injured worker underwent right shoulder arthroscopic rotator cuff repair, distal clavicle resection, biceps tenodesis and subacromial decompression. The 1/29/15 post-op note requested authorization for a 30-day trial of a transcutaneous electrical stimulation unit, Meds4-INF Stimulator unit, and associated supplies. The treating physician stated that using an interferential unit immediately post-operatively can effectively allow the patient an early return to function. The 2/6/15 treating physician report cited constant right shoulder pain that was alleviated with ice and medication. The treatment plan indicated that the patient was to begin a home exercise program, continue activity as tolerated, use medications as instructed, and use hot and cold modalities with stretching as tolerated. She was to begin physical therapy in 4 weeks. A 2/19/15 request for a 30-day trial of a Meds4-INF Stimulator unit, and associated supplies was submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Meds4-INF Stimulator Unit x 30 day trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; TENS, chronic pain; Interferential Current Stimulation (ICS). Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Postoperative treatment and DME.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The Meds4-INF Stimulator is listed by the FDA as a powered muscle stimulator, TENS unit and interferential unit. The California MTUS guidelines do not recommend interferential current (IFC) stimulation as an isolated intervention. Guidelines indicate that a one-month IFC trial may be indicated for post-operative conditions if there is significant pain that limits the ability to perform exercise programs/physical therapy treatment. MTUS guidelines recommend TENS use as a treatment option for acute post-operative pain in the first 30 days after surgery. TENS appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. Guidelines state that the proposed necessity of the unit should be documented. Other forms of muscle stimulation, including neuromuscular electrical stimulation, micro-current electrical stimulation, and galvanic stimulation, are not recommended. Guidelines have not been met. The patient underwent right shoulder arthroscopic surgery. There was no indication that the patient would be unable to perform post-op physical therapy exercise or treatment, or that post-operative pain management would be ineffective. There was no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative or immediate post-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. There is no guideline support for powered muscle stimulation in the post-operative shoulder patient. Therefore, this request is not medically necessary.

**Purchase Conductive garment:** 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 Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** As the associated durable medical equipment is not supported, this request is not medically necessary.

**Purchase Electrodes:** 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  
Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** As the associated durable medical equipment is not supported, this request is not medically necessary.