

<b>Case Number:</b>	CM15-0053840		
<b>Date Assigned:</b>	03/27/2015	<b>Date of Injury:</b>	08/08/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2015

### 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:

The injured worker is a 62-year-old male who sustained an industrial injury on 8/8/14. Injury occurred while traveling in the sleeper berth of a truck, he was thrown out of the berth, striking the back of the driver and passenger seats, and landing on the floor board. He reported injuries to the neck, mid back, low back, right elbow and left ankle. Conservative treatment included physical therapy, acupuncture, activity modification, anti-inflammatory medications, and analgesic medications. The 1/26/15 right shoulder MRI impression documented lateral outlet stenosis impingement related tendinosis and peritendinitis of the supraspinatus and infraspinatus tendons distally about the footplate. There was a 6 mm rim rent tear of the far anterodistal supraspinatus tendon. There was no evidence of a rotator cuff macro tear. Findings represented a likely non-displaced inferior glenoid labrum tear. Findings documented inflamed hypertrophic acromioclavicular (AC) joint arthrosis. The acromion demonstrated a type II configuration with slight lateral downsloping and thickening of the coracoacromial acromial ligament attachment contributing to an outlet encroachment. The 2/6/15 treating physician report cited constant neck, bilateral shoulder, and low back pain, and headaches. Difficulty was noted with activities of daily living, overhead activities, and sleeping. Right shoulder exam documented atrophy in the deltoid region, and tenderness to palpation over the AC joint, coracoid process, and anterior and middle shoulder joint. Neer's, Hawkin's tests, drop arm, and anterior apprehension tests were positive. Right shoulder range of motion was painful with flexion 143, extension 28, abduction 140, adduction 44, external rotation 75, and internal rotation 65 degrees. Grip strength was 38/35/37 pounds right and 10/98/95 pounds left. Imaging showed impingement, supraspinatus

tear, and non-displaced tear of the inferior glenoid labrum. The treatment plan included request for authorization for right shoulder arthroscopy with repair of the rotator cuff and Mumford procedure, and associate surgical items/services. Authorization was requested for 14-day rental of a Surgi-Stim multimodality stimulator. The 2/27/15 treating physician report documented persistent right shoulder pain with difficulty in overhead activities and lifting. The 3/2/15 utilization review non-certified the request for 14-day rental of a Surgi-Stim multimodality stimulator based on an absence of guideline support.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Associated surgical service: Surgi-Stim Multi Modality Stimulator - 14 day rental:** 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), Shoulder, Neuromuscular electrical stimulation (NMES devices); Interferential current stimulation (ICS).

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

**Decision rationale:** The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines state that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-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. Therefore, this request is not medically necessary.