

Case Number:	CM15-0000667		
Date Assigned:	01/12/2015	Date of Injury:	03/18/2002
Decision Date:	03/11/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/02/2015

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: 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:

The injured worker is a 73 year old male who sustained an industrial injury on 03/18/2002. The mechanism of injury is not documented. The diagnoses have included impingement syndrome, right shoulder, associated with degenerative changes of the rotator cuff and findings indicative of a recent tear of the rotator cuff per MRI performed on 12/20/2007, rotator cuff tear, left shoulder per MRI performed on 07/27/2004, massive full thickness rotator cuff tear with retraction of musculotendinous unit of supraspinatus and infraspinatus tendons and large bursal tear of the subscapularis tendon, right shoulder per MRI performed on 02/29/2012 and status post left arthroscopic rotator cuff repair, subacromial decompression and distal clavicle resection and biceps tenodesis 11/13/2010. At presentation on 11/14/2014 the injured worker (IW) had positive Hawkins and Neer impingement signs of the right shoulder, pain with positive arc from 90 to 110 degree active forward flexion, forward elevation and abduction. He had no instability to ligamentous stress testing. The provider requested electrical stimulator device for use postoperatively. On 12/09/2014 utilization review non-certified the request for an electrical stimulator device noting this device would not be indicated for postoperative use as the need for operative intervention in this individual has not been established. MTUS Guidelines were cited. On 01/02/2015 the injured worker submitted an application for IMR for review of the requested electrical stimulator device.

IMR ISSUES, DECISIONS AND RATIONALES

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

E-STIM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder Chapter, Electrical stimulation

Decision rationale: The patient presents with pain and weakness in both of his shoulders. The patient is *s/p* left contralateral shoulder rotator cuff repair on 11/03/10. The request is for E-STIM. ODG-TWC, Shoulder Chapter under Electrical stimulation, E-stim is not recommended. For several physical therapy interventions and indications (e.g., thermotherapy, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy (Philadelphia, 2001). "Given the lack of the guidelines support E-Stim for shoulder pain, the request IS NOT medically necessary.