

Case Number:	CM13-0036834		
Date Assigned:	12/13/2013	Date of Injury:	09/15/2012
Decision Date:	02/12/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, 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 physician 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 claimant is a 53-year-old gentleman who was injured in a work related accident on September 15, 2012. The records indicate an injury to the right shoulder for which the claimant has recently been authorized for surgical process. The specifics in regards to the claimant's shoulder injury are not stated. It is indicated that an arthroscopy has been scheduled.

IMR ISSUES, DECISIONS AND RATIONALES

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

neuromuscular electric stimulator and supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Based on California MTUS Guidelines, the role of a neural muscular electrical stimulator device is only recommended following a rehabilitation program after a stroke. There is no indication for its use in the chronic or acute pain setting. The specific use of this agent following a shoulder arthroscopy would not be indicated; therefore, the request is non-certified.

ThermaCooler system with a water circulating wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

Decision rationale: The MTUS guidelines are silent on this issue. When looking at the Official Disability Guideline criteria, a combination therapy device including a heat/cold compressive unit would not be indicated. The ODG states that there are no high published quality studies supporting the use of such a device in the postsurgical or acute pain setting. The specific request of this combination device would not be indicated; therefore, the request is non-certified.