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| Case Number: | CM13-0057713 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 12/05/2012 |
| Decision Date: | 04/14/2014 | UR Denial Date: | 11/08/2013 |
| Priority: | Standard | Application Received: | 11/25/2013 |

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 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 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 claimant is a 55-year-old gentleman who was injured on December 5, 2012. The medical records provided for review documented that he has been recently certified to undergo right shoulder arthroscopy and debridement versus repair of the rotator cuff. Within the medical records there is documentation that the claimant is utilizing Norco, ibuprofen, Tramadol, and Omeprazole.

IMR ISSUES, DECISIONS AND RATIONALES

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

14 DAYS OF A COLD THERAPY UNIT: 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: While not addressed by the California MTUS or ACOEM Guidelines, the Official Disability Guidelines do not recommend cold therapy units for the shoulder, although they do support their use for other body parts for rental for seven days. Adjunctive cold therapy unit for fourteen days has been requested; however, based upon the ODG, the request cannot be

supported as the at home application of cold packs would serve the same purpose. As such, the request is noncertified.

REFILLED MEDICATIONS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician's Desk Reference 2013

Decision rationale: Medication refills have been requested, but the names of the specific medications to be addressed are not provided. As stated this requests cannot be certified without identifying the medications to be refilled. The request is noncertified.

PERMANENT USE OF INTERFERENTIAL STIMULATOR (IFC) UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203,Chronic Pain Treatment Guidelines Page(s): 118-119.

Decision rationale: The ACOEM Guidelines do not recommend permanent use of an interferential stimulator. There is no literature to support its use in the perioperative period with this diagnosis and surgical procedure. In addition, there is no documentation to indicate that the claimant will have significant pain postoperatively that will limit his ability to perform exercise programs or activities to warrant it long term use. For this reason, an interferential stimulator unit is not indicated or supported in review of the records. The request is noncertified.