MAXIMUS Federal Services

Case Number:	CM15-0207420		
Date Assigned:	10/26/2015	Date of Injury:	11/08/2014
Decision Date:	12/15/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	10/21/2015

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: Minnesota, Florida
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 injured worker is a 47 year old female, who sustained an industrial injury on 11-08-2014. The injured worker was diagnosed as having bursitis-subacromial-right, arthritis AC joint - right and calcifying tendon of shoulder - right. On medical records dated 09-11-2015, the subjective complaints were noted as right shoulder pain. Objective findings were noted as right shoulder tenderness, cross arm test was positive, and crepitus was noted as well. Impingement test was positive with supraspinatus test and positive Hawkins test. Cervical spine revealed tenderness over trapezium muscle. Treatment to date included medication. The provider recommended surgical intervention. Current medication was listed as Mobic. The Utilization Review (UR) was dated 09-21-2015. A Request for Authorization was dated 09-14-2015. The UR submitted for this medical review indicated that the request for associated surgical services: cold therapy unit was modified and Vicoprofen 7.5 mg #40 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical services: Cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee chapter: Cryotherapies.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

Decision rationale: ODG guidelines indicate continuous flow cryotherapy as an option after shoulder surgery for 7 days. It reduces pain, swelling, inflammation, and the need for narcotics after surgery. Use beyond 7 days is not recommended. The request as stated does not specify if this is a rental or purchase and if rental, the duration of the rental is not known. Utilization review has recommended a 7 day rental consistent with the guidelines. As such, the request for a cold therapy unit as stated is not supported and the medical necessity of the request has not been substantiated.

Vicoprofen 7.5mg #40: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, and Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list.

Decision rationale: Vicoprofen is a short acting opioid. The documentation indicates approval of Norco 10 mg for post-operative use. Norco is a short acting opioid and the addition of Vicoprofen is not recommended. As such, the medical necessity of Vicoprofen is not supported by guidelines.