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| Case Number: | CM14-0149899 | | |
| Date Assigned: | 10/27/2014 | Date of Injury: | 11/15/2013 |
| Decision Date: | 12/03/2014 | UR Denial Date: | 09/05/2014 |
| Priority: | Standard | Application Received: | 09/15/2014 |

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 Hawaii, Washington, and Maryland. 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 injured worker is a 57-year-old male who reported an injury on 11/15/2013. The mechanism of injury was not submitted for clinical review. The diagnosis included symptomatic left shoulder high grade partial rotator cuff tear. The previous treatments included medication, physical therapy, and surgery. Diagnostic testing included a left shoulder MRI with arthrogram. Within the clinical documentation, dated 10/24/2014, it was reported the injured worker required a refill on his pain medication. Provider noted the injured worker's dressing had been changed. A physical examination was not submitted for clinical review. A request was submitted for postoperative cold therapy unit and Norco; however, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op 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, Shoulder Chapter, Continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Continuous-flow cryotherapy.

Decision rationale: The request for post-op cold therapy unit is not medically necessary. The Official Disability Guidelines note continuous flow cryotherapy is recommended after surgery, but not for nonsurgical treatment. Postoperative use may be generally up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries such as muscles strains and contusions has not been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through the use of power to circulate ice water in the cooling packs. The request submitted failed to document the length of the time the provider indicated the injured worker to utilize the equipment. The request failed to provide a treatment site. Additionally, there is lack of postoperative clinical documentation warranting the medical necessity for the request. Therefore, the request is not medically necessary.

Norco 3/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 77-78.

Decision rationale: The request for Norco 3/325mg is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not submitted for clinical review. The request submitted failed to provide the frequency and quantity of the medication. The provider failed to document an adequate and complete physical examination warranting the medical necessity for the request. Therefore, the request is not medically necessary.