

<b>Case Number:</b>	CM14-0215467		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	10/20/2010
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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. 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: New York  
Certification(s)/Specialty: Neurological 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 60 year old female had an injury to her left knee and right shoulder on 10/20/2010. On 03/1/2013 she had arthroscopy of her left knee and a partial meniscectomy with debridement and a chondroplasty of the lateral tibial plateau, medial femoral condyle and patello femoral joint with synovectomy and lateral release marcaine injection. On 18 October she underwent an arthroscopy for an impingement syndrome of the right rotator cuff, synovectomy, bursectomy and excision of a small os acrominale. Utilization review on 12/16/2014 denied a post-op cooling device, post-op IF unit and post-op IF unit monthly supplies. The operative note of 10/28/2014 noted recommendation of an "ice swelling device." The prescription dated 10-20-2014 is for an "ice cooling device x shoulder" as well as an IF unit x shoulder. The progress note of 11/12/2014 indicates the injured worker was using the ice cooling device for right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Post-op ultrasling, DOS: 10/28/14:** 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

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

**Decision rationale:** ODG guidelines do recommend use of a post-operative pillow sling when the repair is for large massive rotator cuff tears. This worker does not have documentation of such a repair. The guidelines do not recommend the abduction pillow sling in arthroscopic repairs.

**Retrospective Post-op ice cooling device, DOS: 10/28/14: 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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - Cold packs are recommended as an option for acute pain. Use of a continuous flow cryotherapy is recommended as an option for up to seven days. If indeed the injured worker was using the unit as of 11/12.2013, guidelines were not followed. The prescription did not list a time limitation.

**Decision rationale:** ODG guidelines note that Cold packs are recommended as an option for acute pain. Use of a continuous flow cryotherapy is recommended as an option for up to seven days. The request did not list a time limitation. Thus the requested service is not medically appropriate or necessary.

**Retrospective Post-op IF unit, DOS: 10/28/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Evidence-Based support

**Decision rationale:** California MTUS note transcutaneous electrotherapy can be used in the treatment of Post-operative pain in the first thirty days. IF treatment is not recommended as an isolated intervention. They note there are no standardized protocols for the use of interferential therapy.

**Retrospective Post-op IF unit monthly supplies, DOS: 10/28/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Evidence based decision support

**Decision rationale:** California MTUS guidelines note IF treatment is not recommended as an isolated intervention. They note there are no standardized protocols for the use of interferential therapy. Since post-operative IF treatment is not recommended, then monthly supplies are not needed.