

<b>Case Number:</b>	CM13-0002145		
<b>Date Assigned:</b>	05/19/2014	<b>Date of Injury:</b>	12/03/2010
<b>Decision Date:</b>	06/13/2014	<b>UR Denial Date:</b>	07/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/19/2013

### 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 Anesthesia, 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 patient is a 50 year old male injured worker with a date of injury of 12/3/10 with related back, right shoulder, right elbow, right forearm, right knee, right leg, and bilateral hand pain. Per a 12/2/13 progress report, he also complains of waking during the night due to pain, dizziness, headaches, symptoms of anxiety and depression, decreased energy levels, numbness and tingling with pain. His diagnoses include right elbow fracture, intervertebral disc disorder with myelopathy cervical region C3-C7; thoracic sprain with degenerative changes in T3-T4, T5-T6 and mild T5-T6 spinal stenosis; intervertebral disc disorder with myelopathy lumbar region L3-S1; right shoulder sprain; right knee sprain/strain; TMJ syndrome; insomnia; and depression. An MRI of the cervical spine dated 3/23/12 revealed C3-C4 through C6-C7 overall degenerative changes with mild disc bulging resulting in C3-C4, C5-C6, and C6-C7 mild spinal stenosis and C4-C5 moderate spinal stenosis. An MRI of the right shoulder 1/22/13 was notable for a low-grade rotator cuff tear, and he underwent a right shoulder manipulation under anesthesia and subacromial decompression on 2/26/13. He has been treated with physical therapy and medication management. The date of UR decision was 7/2/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PAIN CARE 3200 - PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Shoulder Chapter- Postoperative pain pump.

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

**Decision rationale:** The MTUS Chronic Pain and ACOEM Guidelines do not address the use of pain pumps. With regard to postoperative pain pumps, the ODG states, " Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Before these studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case series and poorly designed, randomized, controlled studies with small populations. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically, shoulder and knee procedures." As the treatment is not recommended by the ODG Guidelines, the request is not medically necessary and appropriate.

**MOTORIZED COLD THERAPY UNIT - PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoudler 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).

**Decision rationale:** The ODG states continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be 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 (eg, muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting." As the ODG only supports the use of cold therapy units for up to 7 days, the currently requested purchase is not medically necessary and appropriate.