

Case Number:	CM13-0026802		
Date Assigned:	11/22/2013	Date of Injury:	06/30/2009
Decision Date:	01/03/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	09/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Interventional Spine 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 physician 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.

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 56 y.o. male with injury from 6/30/09, suffers from chronic neck, upper/mid back, bilateral upper extremity pains. This is an injury from a trip over a chair. An MRI of right shoulder showed SLAP tear and/or anterior labral tear was performed and a right shoudler surgery has been recommended. Arthroscopic surgical request has been authorized but Pain pump for post-operative pain and 30 day use of motorized cold therapy unit are denied based on ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

A pain pump: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG)..

Decision rationale: The California MTUS guidelines are silent regarding post-operative pain pumps. However, the Official Disability Guidelines (ODG) guidelines do not recommend it's

use for post-operative use. Recent studies on pain pumps have not supported their efficacy. The request for a pain pump is not medically necessary and appropriate.

A motorized hot/cold therapy system for thirty (30) days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG)..

Decision rationale: The California MTUS Guidelines do not discuss motorized cold/hot system. The Official Disability Guidelines (ODG) however, supports it's use for only 7 days post-operatively. The current request is for 30 days and recommendation is for denial of the request. The request for a motorized hot/cold therapy system for thirty (30) days is not medically necessary and appropriate.