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| <b>Case Number:</b>   | CM13-0039379 |                              |            |
| <b>Date Assigned:</b> | 12/18/2013   | <b>Date of Injury:</b>       | 07/13/2011 |
| <b>Decision Date:</b> | 05/21/2014   | <b>UR Denial Date:</b>       | 10/02/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/04/2013 |

### 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 Neurology, has a subspecialty in Neuromuscular Medicine 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 41 year old woman who sustained a work related injury on July 13 2011. Subsequently, she developed left shoulder pain. According to a report dated on September 18 2013, the patient was complaining of severe left shoulder pain. X ray of the left shoulder demonstrated signs suggestive of rotator cuff tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COLD THERAPY UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation The Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold/heat packs. ([http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#SPECT](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT)) .

**Decision rationale:** According to ODG guidelines, cold therapy is recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both

acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze® cryotherapy gel. There is no evidence to support the efficacy of cold therapy in this patient who was suffering from a chronic left shoulder pain. Therefore, the request for cold therapy is not medically necessary.

**PAIN PUMP (RENTAL):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, <http://www.worklossdatainstitute.verioiponly.com/odgtwc/shoulder.htm#Postoperativepainpump>

**Decision rationale:** According to ODG guidelines, post op pain pump is 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. A surgeon will insert a temporary, easily removable catheter into the shoulder joint that is connected to an automatic pump filled with anesthetic solution. This "pain pump" was intended to help considerably with postoperative discomfort, and is removed by the patient or their family 2 or 3 days after surgery. There is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Therefore the prescription of pain pump is not medically necessary.