

Case Number:	CM13-0054929		
Date Assigned:	12/30/2013	Date of Injury:	03/29/2012
Decision Date:	03/18/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/18/2013

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. 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:

This is a 5'9", 270 lbs, 44 year-old female LVN who was injured on 3/29/12 while assisting a blind and confused patient into bed. He poked her in the eye and as she stepped away from the patient, she bumped into a wheelchair and fell backwards onto the floor. She reported injury to her right shoulder, elbow, wrist, hip, right leg, low back, mid back and neck. According to the 10/22/13 orthopedic report from [REDACTED], she still had constant 10/10 right shoulder pain; constant 10/10 low and mid back pain; 9/10 constant pain in the right hip, ankle, elbow, wrist, and intermittent 8/10 headaches. The IMR application shows a dispute with the 11/7/13 UR decision. The 11/7/13 UR decision is from [REDACTED] and was based on the 9/24/13 and 10/22/13 medical reports, and was for non-certification for a cold therapy unit, x2 weeks rental, and pain pump, for an upcoming arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Pump for Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder Complaints, ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2006 pages 581-583.

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

Decision rationale: The patient presents with constant severe 10/10 pain in the right shoulder, mid and low back, 2-years after a slip and fall at work, and has current recommendations for right shoulder arthroscopy. The request before me is for a post-operative pain pump purchase. MTUS and ACOEM guidelines did not discuss the pain pump, so ODG guidelines were consulted. ODG, shoulder chapter for the postoperative pain pump specifically states: "Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps." The request is not in accordance with ODG guidelines.

Cold Therapy Unit for two (2) weeks rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder Complaints, ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2006 pages 581-583.

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

Decision rationale: The patient presents with constant severe 10/10 pain in the right shoulder, mid and low back, 2-years after a slip and fall at work, and has current recommendations for right shoulder arthroscopy. The request before me is for a post-operative cold therapy unit rental for 2-weeks. MTUS and ACOEM guidelines did not discuss the cold therapy units, so ODG guidelines were consulted. ODG, shoulder chapter for the cold therapy units specifically states: "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." The request for 2-weeks rental will exceed the ODG recommendations of 7-days. The request as written is not in accordance with ODG guidelines.