

Case Number:	CM13-0065616		
Date Assigned:	01/03/2014	Date of Injury:	06/08/2010
Decision Date:	09/18/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/13/2013

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 Orthopedic Surgery 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 45-year-old female who has submitted a claim for back pain following L5-S1 disc replacement and fusion, improving (01/07/2013) and status post left shoulder arthroscopic subacromial decompression, Mumford procedure (06/28/2013) associated with an industrial injury date of 06/28/2010. Medical records from 05/09/2013 to 11/20/2013 were reviewed and showed that patient complained of left shoulder pain graded 6/10 and lower back pain graded 3/10. Physical examination revealed well-healed arthroscopic portals over the left shoulder and well-healed midline surgical scar over the lumbar area. Decreased left shoulder ROM was noted secondary to pain. Tenderness was noted over bilateral lumbar paraspinal musculature. SLR test was positive on the right at 70 degrees. MMT of lower extremities was 5/5 except right knee extensor, foot evertors, and right great toe extensor (all graded 4/5). X-ray of the left shoulder dated 11/12/2013 revealed excellent distal clavicular resection and no significant glenohumeral arthrosis. X-ray of the lumbar spine dated 05/22/2013 revealed excellent placement of disc replacement at L4-5, pedicle screws are in excellent position at L5-S1, and no sign of solid bony arthrodesis at L5-S1. Of note, the last UR dated 11/22/2013 certified the request for left shoulder arthroscopic revision. Treatment to date has included L4-5 disc replacement and L5-S1 fusion (01/07/2013), left shoulder arthroscopic subacromial decompression and rotator cuff repair, Mumford procedure(06/28/2013), subacromial injection (11/02/2013), transforaminal L4-5 ESI(11/05/2012), physical therapy, Norco, Tizanidine, Lyrica, and Elavil. Utilization review dated 11/22/2013 denied the request for pain pump because it was narcotic and/or NSAID would suffice postoperative pain control. Utilization review dated 11/22/2013 modified the request for motorized hot/cold unit for 30 days to 7-day CTU rental because ODG allows only a 7-day CTU rental. Utilization review dated 11/22/2013 denied the request for pro-sling with abduction pillow because the claimant does not fit the criterion for use of sling/abduction pillow.

Utilization review dated 11/22/2013 denied the request for Sprix 15.75mg nasal spray because the request was not medically necessary for postoperative pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

PAIN PUMP: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Drug-Delivery Systems (IDDSs) Page(s): 52-54.

Decision rationale: According to pages 52-54 of the MTUS Chronic Pain Medical Treatment Guidelines, permanently implanted intrathecal (intraspinal) infusion pumps in the treatment of chronic intractable pain are considered medically necessary when used for the treatment of nonmalignant pain with a duration of greater than 6 months and all of the following criteria are met: (1) documentation of failure of 6 months of other conservative treatment modalities; (2) intractable pain with objective documentation of pathology in the medical record; (3) further surgical intervention or other treatment is not indicated or likely to be effective; (4) psychological evaluation has been obtained; (5) no contraindications to implantation exist; and (6) a temporary trial of spinal opiates has been successful prior to permanent implantation. In this case, there was no diagnosis of chronic intractable pain which is part of the criteria for pain pump. There was no documentation of psychological evaluation as well as discussion concerning conservative treatment failure. Moreover, the patient was scheduled for left shoulder arthroscopic revision (UR 11/22/2013). The patient did not meet the aforementioned criteria for intrathecal infusion pumps. Therefore, the request for pain pump is not medically necessary.

MOTORIZED HOT/COLD UNIT FOR 30 DAYS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: The MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Aetna was used instead. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no

studies evaluating its use as a heat source. In this case, the patient complained of low back and left shoulder pain. There was no discussion addressing the need for hot/ice machine. The guidelines do not recommend hot/ice machine as it does not prove to be superior over conventional heat/ice pack application. Therefore, the request for motorized hot/cold unit for 30 days is not medically necessary.

PRO-SLING WITH ABDUCTION PILLOW: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Post Op Pillow Sling.

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

Decision rationale: The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Official Disability Guidelines (ODG) was used instead. The ODG recommends postoperative abduction pillow sling as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. In this case, the patient underwent left shoulder arthroscopic rotator cuff repair, subacromial decompression and Mumford procedure (06/28/2013). However, the guidelines only recommend the use of abduction pillow sling after open repair of large and massive rotator cuff tears. There is no discussion concerning need for variance from the guidelines. Therefore, the request for Pro-Sling with abduction pillow is not medically necessary.

SPRIX 15.75MG NASAL SPRAY FOR POSTOPERATIVE PAIN: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Sprix (ketorolac tromethamine nasal Spray).

Decision rationale: The MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to the ODG, Sprix is recommended for the short-term management of moderate to moderately severe pain requiring analgesia at the opioid level. The total duration of use should be for the shortest duration possible and not to exceed 5 days. In this case, a left shoulder arthroscopic revision was certified on the last UR (11/22/2013). It was unclear if the procedure was done since medical records submitted were from 05/09/2013 to 11/20/2013. There was no discussion stating that the nasal spray will be used only for 5 days.

In addition, the request failed to indicate the quantity of nasal spray to be dispensed. Therefore, the request for Sprix 15.75mg Nasal Spray for Postoperative Pain is not medically necessary.