

<b>Case Number:</b>	CM14-0005077		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	08/10/2013
<b>Decision Date:</b>	06/10/2014	<b>UR Denial Date:</b>	01/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2014

### 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:

According to the records made available for review, this is a 35-year-old male with an 8/10/13 date of injury and status post arthroscopy of the left shoulder on 12/11/13. At the time (12/11/13) of request for authorization for retrospective request (date of service 12/11/2013): purchase of water-circulating cold pad with pump and retrospective request (date of service: 12/11/2013): durable medical equipment (DME) - pain pump for the left shoulder, there is documentation of subjective (left shoulder pain) and objective (tenderness to palpation over the anterior aspect of the left shoulder, marked apprehension to external rotation with tenderness, and clicking and catching) findings, current diagnoses (left shoulder derangement and shoulder joint pain), and treatment to date (left shoulder arthroscopy on 12/11/13).

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **RETROSPECTIVE REQUEST (DATE OF SERVICE 12/11/2013): PURCHASE OF WATER-CIRCULATING COLD PAD WITH PUMP: 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, 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) Shoulder, Polar Care (Cold Therapy Unit).

**Decision rationale:** MTUS does not address this issue. ODG identifies that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. Within the medical information available for review, there is documentation of diagnoses of left shoulder derangement and shoulder joint pain. In addition, there is documentation of status post left shoulder arthroscopy on 12/11/13. However, the requested purchase of water-circulating cold pad with pump exceeds postoperative cryotherapy guidelines (up to 7 days, including home use). Therefore, based on guidelines and a review of the evidence, the request for retrospective request (date of service 12/11/2013): purchase of water-circulating cold pad with pump is not medically necessary.

**RETROSPECTIVE REQUEST (DATE OF SERVICE: 12/11/2013): DURABLE MEDICAL EQUIPMENT (DME) - PAIN PUMP FOR THE LEFT SHOULDER:** 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, 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) Shoulder, Postoperative Pain Pump.

**Decision rationale:** MTUS does not address this issue. ODG identifies that post-operative pain pump is not recommended and that 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 measure. Therefore, based on guidelines and a review of the evidence, the request for retrospective request (date of service: 12/11/2013): durable medical equipment (DME) - pain pump for the left shoulder is not medically necessary.