

Case Number:	CM14-0107022		
Date Assigned:	08/01/2014	Date of Injury:	10/28/2011
Decision Date:	11/07/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/10/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain 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 58 year old female who sustained an industrial injury on 10/28/2011. The operative report documents the patient underwent left shoulder arthroscopic surgery with rotator cuff repair, debridement, partial synovectomy, bursectomy, and acromioplasty, performed on 6/12/2014. Requests were submitted for shoulder ultra-sling, pain pump and cold therapy unit. A prior peer review on 6/20/2014 modified the the request for purchase of CTU to allow 7 day rental, non-certified pain pump, and certified the request for sling for left shoulder post op DME. According to the PTP PR-2 dated 7/15/2014, the patient complains of left shoulder pain, she had surgery on the left shoulder on 6/11/2014, pain is rated 7/10. She also complains of cervical, right shoulder and bilateral wrist pain. Examination of the left shoulder documents painful and limited ROM, tenderness, and pain on supraspinatus press. Work status is to remain off work. Plan of treatment is refer to MD for medication, request chiropractic 2x4, post-op PT 2x6 for left shoulder, and F/U with [REDACTED] orthopedic to check progress of left shoulder post-surgery

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative CTU (Cold Therapy Unit) purchase: 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, Continuous-flow cryotherapy

Decision rationale: According to the guidelines, short term rental, up to 7 days, of a continuous cryotherapy device is recommended as an option after surgery, but not for nonsurgical treatment. The patient was undergoing left shoulder arthroscopic surgery. In the initial postoperative course, up to 7 day use of a CTU is recommended. Beyond the initial 7 days, standard cold packs can be utilized if desired. Consequently, purchase of a cold therapy unit is not medically necessary.

Postoperative pain 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

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

Decision rationale: According to the guidelines, postoperative pain pumps are not recommended. 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. The use of a pain pump device postoperatively following arthroscopic shoulder procedure is not supported by the guidelines. The patient would be able to manage pain with judicious use of standard oral medications and palliative measures of ice/heat. As this device is not recommended within evidence-based guidelines, the medical necessity is not established. The request is not medically necessary.