

Case Number:	CM14-0015082		
Date Assigned:	02/28/2014	Date of Injury:	12/03/2010
Decision Date:	10/10/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/06/2014

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:

58 year old female with an industrial injury dated 12/03/10. MRI demonstrates that the patient has a herniated disc at L4-L5 and L5-S1 with annular tears. Exam note 12/02/13 states the patient returns with radiating back pain. Upon physical exam there was evidence of tenderness in the neck muscles and over the anterior and posterior aspects of the shoulders as well. The pain is in the bicipital groove with strength noted as a 4/5. Range of motion of the cervical spine is limited, abduction is at 90° on the right and 160° on the left, with an external rotation is at 80° on both sides. MRI of the left shoulder demonstrates the need for postoperative physical therapy 3 times a week for 4 weeks. Treatment includes pain management for oral and injectable medications, a right shoulder arthroscopy debridement versus repair, a repeat injection to the lumbar spine with the possibility of lumbar surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medical clearance consisting of labs (CBC w/differential, PT, PTT, INR, HGB, UA COMPLETE, BMP, HFP): 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 Other Medical Treatment Guideline or Medical Evidence: <http://www.brighamandwomens.org/gms/Medical/preopprotocols.aspx>

Decision rationale: CA MTUS and ODG are silent on the issue of preoperative clearance. Alternative guidelines were therefore referenced.<http://www.brighamandwomens.org/gms/Medical/preopprotocols.aspx> States that patients greater than age 40 require a CBC; males require an ECG if greater than 40 and female is greater than age 50; this is for any type of surgery. In this case the claimant is 58 years old and does not have any evidence in the cited records from 12/2/13 of significant medical comorbidities to support a need for preoperative clearance including any labs. Therefore, medical clearance consisting of labs (CBC w/differential, PT, PTT, INR, HGB, UA complete, BMP, and HFP) is not medically necessary and appropriate.

Shoulder sling with abduction pillow - right shoulder: 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) Shoulder, Abduction pillows,

Decision rationale: CA MTUS/ACOEM is silent on the issue of abduction pillow. Per the ODG criteria, abduction pillow is recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case there is no indication for need for open rotator cuff repair and therefore, shoulder sling with abduction pillow - right shoulder is not medically necessary and appropriate.

Cold therapy unit rental - unspecified duration: 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) Shoulder Chapter, Continuous Flow Cryotherapy

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore cold therapy unit rental - unspecified duration is not medically necessary and appropriate.

Pain pump: 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), Shoulder Chapter, postoperative pain pumps.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder pain pumps. Per the Official Disability Guidelines, Online edition, Shoulder Chapter, regarding postoperative pain pumps "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." As the guidelines do not recommend pain pumps then the determination is Pain pump is not medically necessary and appropriate.