

Case Number:	CM14-0110387		
Date Assigned:	09/19/2014	Date of Injury:	10/17/2011
Decision Date:	10/20/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/15/2014

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 and Rehabilitation 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 54-year-old female who has submitted a claim for rupture rotator cuff, complete associated with an industrial injury date of October 17, 2011. Medical records from 2012 through 2014 were reviewed, which showed that the patient complained of pain in the cervical spine and right shoulder rated at 8/10 as well as anxiety, depression and loss of sleep due to pain. Examination revealed decreased painful cervical range of motion with tenderness over the paravertebral muscles and muscle spasms. Shoulder depression and cervical compression were positive. ROM was decreased and painful. There was also tenderness of the acromioclavicular joint, anterior shoulder, glenohumeral joint, lateral shoulder, posterior shoulder, supraspinatus and trapezius. Supraspinatus press test was positive. MRI of the shoulder dated December 27, 2012 revealed rotator cuff tear with retraction of the muscle and tendon and possibly associated with tear of the long head of the biceps tendon. Treatment to date has included medications, acupuncture and chiropractic treatment. The patient was authorized to undergo a redo-right shoulder rotator cuff repair and subacromial decompression. Utilization review from June 17, 2014 denied the request for Cold therapy unit and Pain pump. The request for pain pump was denied because the ODG guidelines do not recommend its use and there was no evidence that the patient was unable to tolerate first line oral medications. The request for cold therapy was modified to cold therapy unit x 7 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Section, Continuous-flow Cryotherapy

Decision rationale: CA MTUS does not specifically address cold therapy units. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. According to the ODG, cold therapy unit is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. In this case, the patient was recommended with cold therapy unit for postoperative use after a redo-right shoulder rotator cuff repair and subacromial decompression. Guidelines state that postoperative use may be up to 7 days. The medical necessity for cryotherapy has been established. However, the present request as submitted failed to specify intended duration of treatment period and if device is for rental or purchase. The request is incomplete; therefore, the request for a cold therapy unit is not medically necessary or appropriate.

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)

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

Decision rationale: According to the 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, the patient was prescribed pain pump for postoperative use. 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. The patient did not meet the aforementioned criteria for intrathecal infusion pumps. Therefore, the request for a pain pump is not medically necessary or appropriate.

