

Case Number:	CM14-0122231		
Date Assigned:	08/06/2014	Date of Injury:	09/22/2008
Decision Date:	09/11/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	08/04/2014

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 Emergency Medicine and is licensed to practice in New York. 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 51-year-old male who was injured on September 22, 2008. The patient continued to experience pain in both shoulders, left greater than right. Physical examination was notable for positive impingement and Neer Test in the left shoulder. Diagnoses included right shoulder rotator cuff tear, bilateral shoulder impingement syndrome, and bilateral carpal tunnel syndrome. Treatment included medications and surgery. Requests for authorization for purchase of post-operative cold therapy unit and post-operative pain pump for 2 days were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative cold therapy unit, purchase QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Shoulder (Acute and Chronic) 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: Continuous-flow cryotherapy 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 post-operative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. In this case, the patient is requesting the purchase of a cold therapy unit. There is no indication for the use of cold therapy unit beyond 7 days. The request for a post-operative cold therapy unit is not medically necessary.

Post operative pain pump x 2 days QTY 1.00:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems. Decision based on Non-MTUS Citation Official Disability Guidelines - Shoulder (Acute and Chronic) 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, Post-operative pain pump.

Decision rationale: 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. Therefore, the request for a post-operative pain pump is not medically necessary.