

Case Number:	CM14-0130364		
Date Assigned:	08/20/2014	Date of Injury:	02/19/2014
Decision Date:	09/23/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/15/2014

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 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:

The patient is a 58-year-old female who has submitted a claim for cervical disc herniation, left hand trigger thumb, right shoulder calcific tendonitis, rotator cuff tear and longitudinal tear of the biceps tendon; associated with an industrial injury date of 02/19/2014. Medical records from 2014 were reviewed and showed that patient complained of neck and shoulder pain. The patient reports numbness and tingling going down her left hand. Physical examination showed weakness of the rotator cuff. Pain with supraspinatus testing and forward flexion and abduction was noted. Lhermitte's test was positive. Tenderness was noted with shooting pain and numbness and tingling down the left arm in the C5-C6 distribution. Treatment to date has included medications and physical therapy. Utilization review, dated 07/29/2014, modified the request for cold therapy unit for post operative pain and swelling; and denied the request for Oxycontin because there was no clear indication that Vicodin was insufficient to manage the patient's post-operative pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Treatment Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel

Syndrome section, Continuous cold therapy Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: California Medical Treatment Utilization Schedule (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, the Aetna Clinical Policy Bulletin was used instead. Aetna considers the use of hot/ice machines and similar devices experimental and investigational for reducing pain and swelling after surgery or injury. Studies failed to show that these devices offer any benefit over standard cryotherapy with ice bags/packs. In addition, Official Disability Guidelines (ODG), Carpal tunnel syndrome section, states that continuous cold therapy is recommended as an option only in the postoperative setting, with regular assessment to avoid frostbite. Postoperative use generally should be no more than 7 days, including home use. In this case, the request for right shoulder arthroscopy, subacromial decompression, biceps tenodesis, rotator cuff repair, and resection of calcium deposit was approved. A cold therapy unit was requested to address postoperative pain and swelling. Lastly, the present request as submitted failed to specify the duration of use and body part to be treated, and whether the request was for rental or purchase of the cold therapy unit. Therefore, the request for cold treatment unit is not medically necessary.

Oxycontin 20 MG #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As stated on page 78 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, a request for Vicodin and Oxycontin was made for postoperative pain management. However, the request for Vicodin has been approved, and there is no discussion regarding insufficient pain relief from Vicodin necessitating concurrent use of two opioids. Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Oxycontin 20mg #20 is not medically necessary.