

Case Number:	CM14-0174714		
Date Assigned:	10/24/2014	Date of Injury:	04/27/2012
Decision Date:	12/03/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/20/2014

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 claimant is a 58-year-old female with reported industrial injury of 04/27/12. Exam note from 12/18/13, there was mention of the patient having multiple diagnoses that included cervical sprain strain, cervical intervertebral disc disorder, lumbar sprain strain, sacroiliac sprain strain, lumbosacral IVD displacement, knee sprain strain, chondromalacia patella, patella tendon tendonitis, left rotator cuff tear, and no clearly detailed objective physical examination findings were listed. There was mention that the patient needed left shoulder surgery and was to remain off of work. No specific detailed objective physical examination findings were listed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Q-Tech Cold Therapy Recovery System with wrap: 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) Shoulder, Continuous flow cryotherapy

Decision rationale: The California MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to Official Disability Guidelines, 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 post-operatively for the cryotherapy unit. Therefore, this request is not medically necessary.

Non-Programmable 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, Chapter Shoulder, Post operative pain pumps

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 pumps Other Medical Treatment Guideline or Medical Evidence: Ciccone WJ 2nd, Busey TD, Weinstein DM, Walden DL, Elias JJ. Assessment of pain relief provided by interscalene regional block and infusion pump after arthroscopic shoulder surgery. Arthroscopy. 2008 Jan;24(1):14-9; and Matsen FA 3rd, Papadonikolakis A. Published evidence demonstrating the causation of glenohumeral chondrolysis by p

Decision rationale: The California 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." In addition there are concerns regarding chondrolysis in the peer reviewed literature with pain pumps in the shoulder postoperatively. As the guidelines and peer reviewed literature does not recommend pain pumps, the request is not medically necessary.

Pro-Sling with Abduction Pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chapter 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, Abduction pillow

Decision rationale: The California MTUS/ACOEM is silent on the issue of abduction pillow. Per the Official Disability Guidelines 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 this request is not medically necessary.

Q-Tech DVT Prevention System: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chapter 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, Cold compression therapy

Decision rationale: The California MTUS/ACOEM is silent on the issue of cold compression therapy. According to the Official Disability Guidelines, Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. As the guidelines do not recommend the requested DME, the request is not medically necessary.