

Case Number:	CM14-0063519		
Date Assigned:	07/11/2014	Date of Injury:	04/09/2010
Decision Date:	08/13/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/06/2014

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 Hand Surgery and is licensed to practice in Texas. 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 injured worker is a 53-year-old male with a reported date of injury of 04/09/2010. The mechanism of injury was noted to be a fall. His diagnoses were noted to include status post L4-5 laminotomy, multilevel degenerative disc disease, 3 joint complex disorder, retrolisthesis of L3 on 4, L4 on 5 and L5 on S1. His previous treatments were noted to include lumbar epidural steroid injections, acupuncture, physical therapy, surgery, and a spinal cord stimulator. The progress note dated 11/20/2013 revealed the injured worker had continued low back pain after multiple procedures and his legs gave out from time to time, and was usually afraid he was about to fall. The injured worker had been utilizing a cane with his right for approximately 3 years. The physical examination revealed right shoulder tenderness under the acromion. The area of the biceps tendon was tender as well. The range of motion was noted to be right/left abduction was to 150/180 degrees, flexion was to 160/180 degrees, external rotation was to 90/90 degrees, internal rotation was 50/90 degrees, abduction was 30/40 degrees, and extension was 30/40 degrees. The impingement test noted positive Neer's and Hawkins to the right shoulder. The examination of the cervical spine revealed a normal range of cervical motion and the Spurling's maneuvers were negative. The Request for Authorization form was not submitted within the medical records. Therapy request was for a postoperative cold therapy unit with shoulder wrap and post-op pain pump, however, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op Cold Therapy Unit with shoulder wrap: 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, Cold Compression therapy.

Decision rationale: The Official Disability Guidelines do not recommend cold compression therapy in the shoulder, as there are no published studies. It may be used for other body parts. There has been a random controlled trial underway since 2008 to evaluate and compare clinical postoperative outcomes for injured workers using an active cooling and compression device, and those using ice packs and elastic wrap after acromioplasty or arthroscopic rotator cuff repair, but the results are not available. The guidelines do not recommend cold compression therapy to the shoulders since there are no published studies, and there is a lack of documentation regarding a shoulder surgery to warrant a postoperative cold therapy unit with shoulder wrap. Therefore, the request for post-operative cold therapy unit with shoulder wrap is not medically necessary and appropriate.

Post-op 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) Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, postoperative pain pump.

Decision rationale: The Official Disability Guidelines do not recommend postoperative pain pumps. The guidelines state three recent moderate quality random controlled trials 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. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically , shoulder and knee procedures. The pain pump was intended to help considerably with postoperative discomfort, and is removed by the patient or their family 2 or 3 days after surgery. 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. There is a lack of documentation regarding shoulder surgery to warrant a post-op pain pump. Furthermore, there is a lack of clinical findings regarding shoulder surgery requested or conservative measures attempted. Therefore, the request for a post-operative pain pump is not medically necessary and appropriate.

