

Case Number:	CM14-0209304		
Date Assigned:	12/22/2014	Date of Injury:	06/20/2011
Decision Date:	02/13/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/15/2014

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:

According to the records made available for review, this is a 46-year-old male with a 6/20/11 date of injury. At the time (11/6/14) of the request for authorization for associated surgical services: Pain Pump for Purchase, associated surgical services: Interferential Unit for 1-2 months Rental, associated surgical services: Cold Therapy Unit for Purchase, and associated surgical services: Shoulder sling for Purchase, there is documentation of subjective (weakness of his right shoulder to external rotation with severe pain with overhead activities) and objective (global tenderness about his right shoulder with weakness to external rotation) findings, imaging findings (11/6/14 medical report's reported imaging findings identify MRI shows a near full thickness tear of the rotator cuff (imaging report not available for review)), current diagnoses (clinical and MRI evidence of a large, near full thickness tear of the rotator cuff of the right shoulder), and treatment to date (physical therapy, medication, injections, and rest). There is no documentation of a pending surgery that has been authorized/certified. Regarding associated surgical services: Interferential Unit for 1-2 months Rental, there is no documentation that the IF unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone; and a pending surgery that is medically necessary. Regarding associated surgical services: Cold Therapy Unit for Purchase and associated surgical services: Shoulder sling for Purchase, there is no documentation of a pending surgery that is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Pump for Purchase: 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, Postoperative pain pump.

Decision rationale: MTUS does not address this issue. ODG identifies that post-operative pain pump is not recommended and that 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 measure. Therefore, based on guidelines and a review of the evidence, the request for associated surgical services: pain pump for purchase is not medically necessary.

Interferential Unit for 1-2 months Rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the medical information available for review, there is documentation of diagnoses of clinical and MRI evidence of a large, near full thickness tear of the rotator cuff of the right shoulder. However, there is no documentation that the IF unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. In addition, there is no documentation of a pending surgery that have been authorized/certified. Therefore, based on guidelines and a review of the evidence, the request for associated surgical services: Interferential Unit for 1-2 months Rental is not medically necessary.

Cold Therapy Unit for Purchase: 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 Chapter, Continuous-flow cryotherapy.

Decision rationale: MTUS does not address this issue. ODG identifies continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. Within the medical information available for review, there is documentation of diagnoses of clinical and MRI evidence of a large, near full thickness tear of the rotator cuff of the right shoulder. However, there is no documentation of a pending surgery that has been authorized/certified. In addition, the requested associated surgical services: Cold Therapy Unit for Purchase exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for associated surgical services: Cold Therapy Unit for Purchase is not medically necessary.

Shoulder sling for Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 44-45.

Decision rationale: MTUS reference to ACOEM guidelines identifies that sling/splint for 7 days followed by gentle range of motion exercises, then progressive mobilization is indicated in the management of non-displaced radial head fractures. In addition, MTUS reference to ACOEM guidelines identifies that a sling is recommended in the management of severe cases of biceps tendinosis with gentle range-of-motion exercises of the elbow, but evidence is insufficient or irreconcilable for the shoulder and wrist. Within the medical information available for review, there is documentation of diagnoses of clinical and MRI evidence of a large, near full thickness tear of the rotator cuff of the right shoulder. However, there is no documentation of a pending surgery that has been authorized/certified. Therefore, based on guidelines and a review of the evidence, the request for associated surgical services: Cold Therapy Unit for Purchase is not medically necessary.