

Case Number:	CM15-0105146		
Date Assigned:	06/09/2015	Date of Injury:	10/29/2014
Decision Date:	07/14/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/01/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 46 year old male, who sustained an industrial injury on October 29, 2014. Treatment to date has included work restrictions, occupational therapy, medications, orthopedic surgery consultation, and acupuncture. Currently, the injured worker complains of neck pain and stiffness which radiates into his right upper extremity. He rates his symptoms a 6 on a 10 point scale. He reports right shoulder and right elbow pain. His right shoulder pain radiates into his neck and down into the right elbow. His shoulder pain is constant and he rates the pain a 7 on a 10-point scale. He reports that his right elbow pain is constant and increases with lifting or torqueing. He rates the right elbow pain an 8 on a 10-point scale. An MRI of the right shoulder on April 14, 2015 revealed a nonacid, non-detached labral tear and mild rotator cuff tendinosis without evidence of partial thickness tear or tendon retraction. The diagnoses associated with the request include medial/lateral epicondylitis of the right shoulder, impingement of the right shoulder and cervical strain. The treatment plan includes modified work, arthroscopy of the right shoulder with SLAP labral repair and postoperative pain pump, IF unit and cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

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, 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.

Decision rationale: CA 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 determination is not medically necessary.

IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines galvanic stimulation Page(s): 117.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, Galvanic Stimulation, page 117 and Interferential Current Stimulation, page 118, provide the following discussion regarding the forms of electrical stimulation contained in the requested IF unit: Galvanic stimulation is not recommended by the guidelines for any indication. In addition, interferential current stimulation is not recommended as an isolated intervention. Therefore, the IF unit is not recommended by the applicable guidelines and is therefore not medically necessary.

Cold therapy unit: 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, 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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case, there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore, the determination is not medically necessary.