

Case Number:	CM15-0133011		
Date Assigned:	07/21/2015	Date of Injury:	09/17/2014
Decision Date:	08/26/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/09/2015

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, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

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 76 year old female, who sustained an industrial injury on 09-17-2014 secondary to a slip and fall. On operative report 05-08-2015 the injured worker reported painful range of motion of the left shoulder, tenderness in the subacromial area, positive impingement test and posttraumatic arthrosis of the acromioclavicular joint with tenderness of the area was noted as well. The diagnosis included left shoulder rotator cuff partial tear and left shoulder posttraumatic arthrosis of the acromioclavicular joint. The injured worker underwent an arthroscopic subacromial decompression-extensive, partial distal claviclectomy, diagnostic arthroscopy and placement of the pain pump. The provider requested Retro: Q Tech cold therapy with wrap (days), Retro: Optimum home rehab kit, Retro: non programmable pain pump (indefinite use), and Retro: CPM with pads for shoulder (days).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Q Tech cold therapy with wrap (days) Qty: 21: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 2011, 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) Knee, Continuous-flow cryotherapy.

Decision rationale: The MTUS is silent on the use of cold therapy units. The ODG states continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting." As the ODG only supports the use of cold therapy units for up to 7 days, the request for 21 day rental is not medically necessary. It should be noted that the UR physician has certified a modification of the request for 7 day rental.

Retro: Optimum home rehab kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines exercise Page(s): 46-47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: Per the MTUS CPMTG with regard to exercise, "There is strong evidence that exercise programs, including aerobic conditioning and strengthening are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen." The documentation submitted for review does not adequately specify what is being requested or why it is necessary. Medical necessity cannot be affirmed.

Retro: non programmable pain pump (indefinite use): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, 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) Low Back, Facet joint diagnostic blocks (injections).

Decision rationale: Per the ODG guidelines, facet joint medial branch blocks are not recommended except as a diagnostic tool, citing minimal evidence for treatment. The ODG indicates that criteria for facet joint diagnostic blocks (injections) are as follows: 1. One set of diagnostic medial branch blocks is required with a response of = 70%. The pain response should

last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a sedative during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)] The documentation submitted for review indicates that the injured worker was status post arthroscopic subacromial decompression, partial distal claviclectomy, diagnostic arthroscopy, and placement of pain pump 5/8/15. The request was too non-specific. The type of pain pump was not specified in the request. The request is not medically necessary.

Retro: CPM with pads for shoulder (days) Qty: 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic), CPM.

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 Passive Motion (CPM).

Decision rationale: The MTUS is silent on the use of shoulder CPM rentals. Per ODG TWC with regard to shoulder CPM: "Not recommended after shoulder surgery or for non-surgical treatment. (Raab, 1996) (BlueCross BlueShield, 2005) An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and non-operative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength." As the request is not recommended by the guidelines, it is not medically necessary.