

Case Number:	CM15-0184489		
Date Assigned:	09/25/2015	Date of Injury:	07/17/2013
Decision Date:	10/30/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/18/2015

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, Oregon, Washington
 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 65 year old female with a date of injury on 07-17-2013. The injured worker is undergoing treatment for full thickness left rotator cuff tear. A physician progress note dated 07-20-2015 documents the injured worker has locking, and decreased range of motion and decreased strength with signs and symptom of impingement. She has marked tenderness elicited to palpation over the anterior aspect of the shoulder. Range of motion of the left shoulder is limited with a decrease of 20 degrees of abduction. Grip strength is 40-40-30 on the right and 20-20-20 on the left. Impingement test I and II are positive as is the drop arm test. Treatment to date has included diagnostic studies, medications, physical therapy, activity modifications, and injections. A Magnetic Resonance Imaging of the left shoulder done on 02-20-2015 reveals a full thickness insertional supraspinatus tear without atrophy. A Magnetic Resonance Imaging of the right shoulder done on 06-16-2015 revealed moderate to severe sprain-tendinosis of the supraspinatus tendon with articular surface partial tearing affecting less than 50% of the cross-section area of the tendon. Sub coracoid bursitis and mild degenerative cyst formation of the glenoid humeral head. The Request for Authorization dated 08-06-2015 includes diagnostic and operative arthroscopy left shoulder with rotator cuff repair, includes anchor and screws-assistant PA, post-operative physical therapy 3 x week for 4 weeks, consult for medical clearance with CBC, CMP, PT-PTT, UA, EKG, and CXR, shoulder sling, Cold therapy unit, IF unit and a Pain Pump. On 08-18-2015 Utilization Review modified the request for Cold Therapy unit purchase to a 7 day rental of a cold therapy unit. Interferential Unit 30 day rental is not certified. Pain Pump purchase is not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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: CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, 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 determination is not medically necessary.

Interferential Unit 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, "Not recommended as an isolated intervention. 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodological issues." As there is insufficient medical evidence regarding use in this clinical scenario, the determination is not medically necessary.

Pain Pump purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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

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. 1.) 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. 2.) ODG Online edition, 2014. 3.) Matsen FA 3rd, Papadonikolakis A. Published evidence demonstrating the causation of glenohumeral chondrolysis by postoperative infusion of local anesthetic via a pain pump. *J Bone Joint Surge Am*. 2013 Jun 19; 95 (12): 1126-34.