

Case Number:	CM15-0020606		
Date Assigned:	02/10/2015	Date of Injury:	12/17/2010
Decision Date:	05/15/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/04/2015

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, New York
Certification(s)/Specialty: Internal Medicine

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 55 year old female, who sustained an industrial injury on 12/17/2010. The initial complaints or symptoms included a twisting injury to the shoulder. The initial diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, x-rays, MRIs, left shoulder surgery, injections, and conservative therapies. Currently, the injured worker complains of right shoulder pain with grinding, catching and weakness. The diagnoses include partial thickness tear of the rotator cuff of the right shoulder with impingement syndrome. The treatment plan consisted of right shoulder surgery (PASTA repair, biceps tendon tenodesis, acromioplasty and Mumford procedure) with assistant surgeon, post-op physical therapy, medical clearance, cold therapy unit purchase (denied), shoulder sling purchase, pain pump purchase (denied), interferential unit 1-2 month rental (denied), and follow-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Continuous Cryotherapy.

Decision rationale: Pursuant to the Official Disability Guidelines, DME: Cold Therapy Unit is not medically necessary. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use maybe for up to seven days, including home use. In the post operative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling and narcotic use; however the effect on more frequently treated acute injuries has not been fully evaluated. In this case, the treating provider is requesting authorization to proceed with a diagnostic and operative arthroscopy to the right shoulder with rotator cuff repair and decompression. In this case, the medical record contains 43 pages and one progress note, the initial orthopedic evaluation dated November 12, 2014. A request was submitted for a right shoulder PASTA repair, biceps tendon tonodesis, acromioplasty and Mumford procedure, suture anchors and screws. Utilization review states the cold therapy unit was already authorized on December 12, 2014. The latest request for authorization (according to the medical documentation submitted) is a request for authorization dated January 23, 2015. That request is not present in the medical record. As noted above, there is no additional medical documentation in the medical record (progress notes). The request for authorization dated January 23, 2015 for the DME cold therapy unit is a duplicate request for the same service. Consequently, based on the medical record documentation and the peer-reviewed evidence-based guidelines, DME: Cold Therapy Unit is not medically necessary.

IF Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Unit Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Interferential Unit.

Decision rationale: Pursuant to the Official Disability Guidelines, Interferential unit (ICS) 1-2 months is not medically necessary. ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments including return to work, exercise and medications area randomized trials have evaluated the effectiveness of this treatment. The findings from these trials were either negative or insufficient for recommendation due to poor's study design and/or methodologic issues. The Patient Selection Criteria should be documented by the medical care provider for ICS to be medically necessary. These criteria include pain is an effectively controlled due to diminished effectiveness of medications; due to side effects of medications; history of substance abuse; significant pain from post operative or acute conditions that limit the ability to perform exercise programs or physical therapy; unresponsive to conservative measures. If these criteria are met, then a one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. In this case, the medical record contains 43 pages and one progress note.

The initial orthopedic evaluation was dated November 12, 2014. A request was submitted for a right shoulder PASTA repair, biceps tendon tonodesis, acromioplasty and Mumford procedure, suture anchors and screws. According to the utilization review, the interferential unit was for a 1 to 2 month rental. Additionally, there are no contemporaneous progress notes on or about the date of authorization (January 23, 2015) with a clinical indication or rationale for an interferential unit. There is no documentation in any progress note requesting the interferential unit with a clinical indication and rationale for its use. Consequently, absent clinical documentation with a clinical indication and rationale, Interferential unit (ICS) 1-2 months is not medically necessary.

Pain Pump: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Section, Post-Operative Pain Pump.

Decision rationale: Pursuant to the Official Disability Guidelines, pain pump is not medically necessary. The guidelines do not recommend postoperative pain pumps. See the ODG for details. In this case, the medical record contains 43 pages and one progress note. The initial and sole orthopedic evaluation was dated November 12, 2014. A request was submitted for a right shoulder PASTA repair, biceps tendon tonodesis, acromioplasty and Mumford procedure, suture anchors and screws. Pain pumps are not recommended by the Official Disability Guidelines. There is insufficient evidence to conclude that direct infusion is as effective or more effective than conventional pre or postoperative pain control using oral, intramuscular or intravenous analgesics. Additionally, there are no contemporaneous progress notes on or about the date of authorization (January 23, 2015) with a clinical indication or rationale for a pain pump. Consequently, absent clinical documentation with a clinical indication and rationale for a pain pump with guideline non-recommendations, pain pump is not medically necessary.