

Case Number:	CM15-0021002		
Date Assigned:	02/10/2015	Date of Injury:	06/20/2011
Decision Date:	03/26/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/03/2015

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 47 year old male, who sustained an industrial injury on 6/20/11. He has reported lower back, right knee and left shoulder. The diagnoses have included left lateral epicondylar tear, radiculopathy, shoulder impingement and right medial meniscus tear. Treatment to date has included x-rays, physical therapy, injections and oral medications. As of the PR2 dated 11/12/14, the injured worker reports pain in the left shoulder. The injured worker has been approved for arthroscopic shoulder surgery. The treating physician requested a pain pump purchase, IF unit 2 month rental and a cold therapy unit purchase. On 1/16/15 Utilization Review non-certified a request for a pain pump purchase, IF unit 2 month rental and a cold therapy unit purchase. The utilization review physician cited the MTUS and ODG guidelines. On 1/29/15, the injured worker submitted an application for IMR for review of a pain pump purchase, IF unit 2 month rental and a cold therapy unit purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of a Pain Pump: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 52.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder section, Pain pump

Decision rationale: Pursuant to the Official Disability Guidelines, purchase pain pump is not medically necessary. Pain pumps are not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. In this case, the injured worker's working diagnoses are elbow MRI lateral epicondylar of tear; MRI lumbosacral spine with degenerative joint disease with 6 mm HNP at L5/S1 with lumbosacral EMG & right greater than left S1 radiculopathy; MRI right medial meniscal tear; MRI right shoulder impingement syndrome. The medical record does not contain the treating orthopedic () progress note. According to the Official Disability Guidelines, pain pumps are not recommended and not supported by the guidelines. Consequently, absent compelling clinical documentation in contravention of the recommended guidelines, purchase pain pump is not medically necessary.

2 month Rental of an IF Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain section, Interferential unit

Decision rationale: Pursuant to the Official Disability Guidelines, two-month rental interferential unit (ICS) is not medically necessary. ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work and exercises and limited evidence of improvement on those recommended treatments. The guidelines enumerate Patient Selection Criteria that should be documented by the medical care provider for ICS to be determined medically necessary. Criteria include, but are not limited to, pain inadequately controlled due to diminished effectiveness of medication or side effects of medications; significant pain from post operative conditions that limit physical therapy treatment; unresponsive to conservative measures. If these criteria are met in 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 injured worker's working diagnoses are elbow MRI lateral epicondylar of tear; MRI lumbosacral spine with degenerative joint disease with 6 mm HNP at L5/S1 with lumbosacral EMG & right greater than left S1 radiculopathy; MRI right medial meniscal tear; MRI right shoulder impingement syndrome. The Patient Selection Criteria, after proper documentation, recommend a one-month clinical trial to permit a physician and physical therapy provider to study its effects and benefits. The Patient Selection Criteria are not documented. Consequently, the guidelines recommend a one-month clinical trial according to the Patient Selection Criteria and, as a result, ICS two-month rental interferential unit is 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, Shoulder

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Back, pain sections, Cryotherapy unit

Decision rationale: Pursuant to the Official Disability Guidelines, cold therapy unit is not medically necessary. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use may be 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 injured worker's working diagnoses are elbow MRI lateral epicondylar of tear; MRI lumbosacral spine with degenerative joint disease with 6 mm HNP at L5/S1 with lumbosacral EMG & right greater than left S1 radiculopathy; MRI right medial meniscal tear; MRI right shoulder impingement syndrome. Continuous flow cryotherapy is recommended as an option after surgery. Postoperative use may be for up to seven days, including home use. However, the documentation does not document the clinical indication and rationale for the unit. Additionally, the request for authorization is for a cold therapy unit. The request does not state the number of days the unit is required. Consequently, absent clinical documentation stating the clinical indication and rationale, the specific number of days, cold therapy unit is not medically necessary.