

Case Number:	CM15-0222132		
Date Assigned:	11/17/2015	Date of Injury:	03/03/2014
Decision Date:	12/30/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	11/12/2015

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: Illinois, California, Texas
 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:

This injured worker is a 45-year-old female who sustained an industrial injury on 3/3/14. Injury occurred when she was pulling a pallet of trash and had an initial twisting injury to the left shoulder. She reported a compensatory right shoulder injury. She was diagnosed with a partial thickness rotator cuff tear and impingement syndrome. She underwent a right shoulder rotator cuff and glenoid labral tear debridement, acromioplasty, resection of the coracoacromial ligament and subacromial bursa, and distal clavicle resection on 3/11/15. The 9/23/15 treating physician report cited progressive grade 8/10 right shoulder pain radiating into the cervical spine and down the arm. Physical exam documented tenderness with severe loss of range of motion. She had minimal ability to externally rotate the shoulder. X-rays showed no increased calcifications in the soft tissues. The injured worker had severe adhesive capsulitis of the right shoulder. Authorization was requested for right shoulder arthroscopy with capsule release, lysis of adhesions, manipulation under anesthesia, and possible biceps tenodesis with associated surgical requests including post-operative pain pump and post-operative cold therapy unit purchase. The 10/19/15 utilization review certified the request for right shoulder surgery. The request for a post-op pain pump was non-certified, as this was not supported by guidelines. The request for purchase of a cold therapy unit was modified to a 7-day rental consistent with guideline recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative pain pump - purchase for the right shoulder: 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.

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

Decision rationale: The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. Given the absence of guideline support for the use of post-operative pain pumps, this request is not medically necessary.

Postoperative cold therapy unit purchase for the right shoulder: 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), Online version: 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: Continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 10/19/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.