

Case Number:	CM15-0059182		
Date Assigned:	04/03/2015	Date of Injury:	03/26/2008
Decision Date:	06/02/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/28/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 56 year old female who sustained a work related injury on March 26, 2008. She was diagnosed with cervical discopathy, cervical radiculitis, and right and left rotator cuff tears. She underwent surgery on both shoulders. Treatment included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and pain medications. Currently, the injured worker complained of persistent neck pain and left shoulder pain radiating down the left upper extremity. The treatment plan that was requested for authorization included purchase of a Pain Pump, purchase of a Cold Therapy Unit, and a thirty day rental of a Transcutaneous Electrical Nerve Stimulation (TENS) unit.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Post-operative pain pump.

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

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding post operative pain pumps, the ODG notes: 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. 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. (Barber, 2002) (Quick, 2003) (Harvey, 2004) (Cigna, 2005) (Cho, 2007) Further three recent RCTs did not support the use of these pain pumps. This study neither supports nor refutes the use of infusion pumps. (Banerjee, 2008) This study concluded that infusion pumps did not significantly reduce pain levels. (Ciccone, 2008) This study found no difference between interscalene block versus continuous subacromial infusion of a local anesthetic with regard to efficacy, complication rate, or cost. (Webb, 2007) I agree with the initial review, that there is not enough evidence-based material to support these opiate pain pumps over oral medicine. The request was appropriately not medically necessary.

Purchase of 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 (ODG), Shoulder chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 48.

Decision rationale: This is a cold therapy unit request. This durable medical equipment item is a device to administer a controlled cold modality, often post surgery or post injury. However, the MTUS/ACOEM guides note in Chapter 3 that "during the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. They are most effective when the patient uses them at home several times a day." Therefore, equipment more elaborate than simple cold packs are simply not needed to administer the cold modalities; the guides note it is something a claimant can do at home with simple home cold packs, without the need for such equipment. As such, this DME would be superfluous and not necessary, and not in accordance with MTUS/ACOEM. The request was appropriately not medically necessary.

30 day rental of a IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 116 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, under interferentials.

Decision rationale: ODG Low Back, under Interferential Stimulators. The MTUS notes that electrical stimulators like interferential units are not recommended as a primary treatment modality, but a one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005) Phantom limb pain and CRPS II: Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985) Spasticity: may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005) Multiple sclerosis (MS): While electrical stimulators do not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007) Further, regarding interferential stimulators for the low back, the ODG notes: Not generally recommended. 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 methodologic issues. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). See the Pain Chapter for more information and references. See also Sympathetic therapy. In this case, the stimulator is not generally recommended due to negative efficacy studies, and the claimant does not have conditions for which electrical stimulation therapies might be beneficial. The request is appropriately not medically necessary.