

Case Number:	CM14-0133152		
Date Assigned:	08/22/2014	Date of Injury:	09/03/2013
Decision Date:	09/24/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/20/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 45-year-old female who reported an injury on 09/03/2013 while she was helping to lower a patient to the ground and had a twisting injury to her neck and shoulder. Diagnosis was disc herniation of the cervical spine at the C5-6 level as well as clinical and a MRI scan evidence of a near full thickness tear of the rotator cuff of the right shoulder with impingement syndrome. Past treatments were chiropractic sessions, physical therapy, and injections. Diagnostic studies include an MRI of the cervical spine revealed multiple levels of significant degenerative disc disease. Past surgeries were not reported. Physical examination on 07/23/2014 revealed complaints of neck pain that radiated to the right shoulder with numbness, tingling, and weakness of the right arm. Examination of the cervical spine revealed normal posture. There was tenderness along the trapezius muscle bilaterally with mild spasm. There was 50 degrees of flexion and extension, 40 degrees of rotation bilaterally, and 40 degrees of bending bilaterally. Neurogenic compression tests were positive on the right. Examination of the right shoulder revealed severe tenderness over the anterior aspect of the shoulder. Range of motion of the right shoulder was to 160 degrees for flexion, 20 degrees of internal rotation, and 10 degrees of external rotation. Range of motion for the right shoulder was normal. Grip strength on the right was 10/10/0 and 40/40/30 on the left. Supraspinatus motor strength was 4+/5. Impingement test was positive. Medications were not reported. Plan was right shoulder with PASTA repair and acromioplasty. The rationale and request for authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op cold therapy unit purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Continuous Flow Cryotherapy.

Decision rationale: The request for post-op cold therapy unit purchase is not medically necessary. The Official Disability Guidelines (ODG) for continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. However, the effect on more frequently treated acute injuries (e.g. muscle strains and contusions) has not been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling bags. Complications related to cryotherapy (i.e. frostbite) are extremely rare but can be devastating. The injured worker has been certified a post-op usage of continuous flow cryotherapy unit for 7 day rental. The guidelines do not state usage is needed for more than 7 days. Therefore, the request is not medically necessary.

Pain pump purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Postoperative Pain Pump.

Decision rationale: The request for pain pump purchase is not medically necessary. The Official Disability Guidelines (ODG) states postoperative pain pump is not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically, shoulder and knee procedures. A surgeon will insert a temporary, easily removable catheter into the shoulder joint that is connected to an automatic pump filled with anesthetic solution. This pain pump was intended to help considerably with postoperative discomfort, and is removed by the patient or their family 2 or 3 days after surgery. 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. The guidelines do not support the use of postoperative pain pump. Therefore, the request is not medically necessary.

