

Case Number:	CM14-0134100		
Date Assigned:	08/27/2014	Date of Injury:	01/07/2014
Decision Date:	09/24/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/21/2014

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 Orthopaedic Surgery 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:

This 51-year-old female correctional supervising cook sustained an industrial injury on 1/7/14. Injury occurred opening a storage door. The 2/3/14 right shoulder MRI impression documented supraspinatus, infraspinatus, and subscapularis tendinosis with no evidence of a full thickness rotator cuff tear. There was osseous acromial outlet narrowing related to mild undersurface spurring of the acromioclavicular joint. There was a significant SLAP lesion with mild biceps tendinosis. Records indicated the patient had marked locking and instability of the right shoulder, painful and limited range of motion, weakness, and positive apprehension testing. Conservative treatment had included medications, injection, activity modification, and physical therapy without sustained benefit. The 7/23/14 treatment plan recommended right shoulder arthroscopy with SLAP repair and requested authorization of post-operative physical therapy, durable medical equipment, and comprehensive pre-operative testing. The 8/5/14 utilization review approved the request for right shoulder arthroscopy with SLAP repair. A request for a cold therapy unit was modified to 7 days use consistent with guidelines. The request for a pain pump was denied based on a lack of guideline support. The pre-operative chest x-ray was denied as the patient was not a smoker and had no history of cardiopulmonary disease.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit, QTY:1: 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, 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 surgery for up to 7 days, including home use. The 8/5/14 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 device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

Pain pump, QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Preoperative chest x-ray, QTY: 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://brighamandwomens.org/gms/Medical/preopprotocols.aspx>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that routine pre-operative chest radiographs are

not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination, or there is a history of stable chronic cardiopulmonary disease in an elderly patient (older than age 70) without a recent chest radiograph within the past six months. Guideline criteria have been met however. Anesthesia is being administered in a lengthy procedure involving recumbency and significant fluid exchange. Therefore, this request is medically necessary.