

Case Number:	CM15-0127987		
Date Assigned:	07/14/2015	Date of Injury:	01/15/2014
Decision Date:	08/18/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	07/02/2015

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

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 60-year-old female, who sustained an industrial injury on 1/15/14. Initial complaints were of head and right shoulder. The injured worker was diagnosed as having right shoulder sprain/strain; left wrist tendinitis with ganglion cyst; lumbosacral sprain/strain with radiculopathy. Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 11/28/14 indicated the injured worker was seen in this office for an initial chiropractic evaluation and examination. She is complaining of ongoing pain in her right shoulder. She reports buzzing in the right ear, which she reports she experienced since her head injury. She reports this buzzing has gradually increased. She reports slight pain over the dorsum of the left wrist. She experiences lower back pain radiating into the right leg with numbness. She experiences right-sided neck pain. On physical examination the provider documents there is a well-healed scar over the dorsum of the left wrist. On cervical spine examination palpation of the cervical spine elicited pain on the right side at C5-6 extending into the right trapezius. She has pain with cervical range of motion on all planes. Deep tendon reflexes in the upper extremities were symmetrical and active bilaterally at the biceps, triceps and brachioradialis. There was no sensory or motor deficit noted in the upper extremities. Foraminal compression and cervical distraction were negative bilaterally. She has pain on palpation over the right shoulder extending into the trapezius and over the supraspinatus tendon. Range of motion was performed with a goniometer with minimal limitations and painful. The Codman's, Yergason's were positive with positive impingement sign. The left wrist examination notes a small ganglion cyst with negative Tinel's, Phalen's and Prayer's. The lumbar spine examination notes pain on palpation. Deep

tendon reflexes in the lower extremities were symmetrical and active bilaterally at patellar and Achilles' tendons. There was no sensory or motor deficit noted in the lower extremities. She has sitting root, Lasegue's; Patrick-Faber's were negative bilaterally. There was no documentation submitted in these notes of impending surgery or discussion of surgery noted for this injured worker. The sciatic notch is positive bilaterally. The provider is requesting authorization of ME Q-Tech Cold Therapy Unit Rental x 21 days; Upper Body Wrap purchase; pain pump purchase; sling purchase and abduction pillow purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

ME Q-Tech Cold Therapy Unit Rental x 21 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter/Cold Compression Therapy Section, Continuous-flow Cryotherapy Section.

Decision rationale: The MTUS Guidelines do not address the use of cold compression therapy for the shoulder. The ODG does not recommend the use of cold compression therapy for the shoulder, as there are no published studies. Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to seven days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The request for a 21-day rental exceeds the recommendations of the established guidelines; therefore, the request for ME Q-Tech Cold Therapy Unit Rental x 21 days is determined to not be medically necessary.

Upper Body Wrap Purchase: 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 Chapter/Cold Compression Therapy Section, Continuous-flow Cryotherapy Section.

Decision rationale: Per manufacturer information, upper body wraps are used to deliver heat or cold to an injured body part. The MTUS Guidelines do not address the use of cold compression therapy for the shoulder. The ODG does not recommend the use of cold compression therapy for the shoulder, as there are no published studies. Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to seven days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The request for a 21-day rental exceeds the recommendations of the established guidelines; therefore,

the request for ME Q-Tech Cold Therapy Unit Rental x 21 days is determined to not be medically necessary. As the request for cold therapy is not supported, the request for upper body wrap purchase is also determined to not be 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 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 Chapter/Post-Operative Pain Pump Section.

Decision rationale: The MTUS guidelines do not address the use of a post-operative pain pump after shoulder surgery; therefore, alternative guidelines were consulted. The ODG does not recommend the use of a post-operative pain pump. 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. 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. There is no documented evidence that suggests that the injured worker cannot manage post-operative shoulder pain with oral medications, therefore, the request for pain pump purchase is determined to not be medically necessary.

Abduction Pillow Purchase x1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 Chapter, Postoperative Abduction Pillow Sling.

Decision rationale: The MTUS Guidelines do not address the use of abduction arm support. The ODG recommends the use of abduction arm support as an option following open repair and massive rotator cuff tears, but not for arthroscopic repairs. This injured worker had an arthroscopic repair. The request for abduction pillow purchase x1 is determined to not be medically necessary.