

<b>Case Number:</b>	CM15-0093955		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	11/14/2006
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2015

### 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, California  
 Certification(s)/Specialty: Family Practice

### 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 58-year-old male, who sustained an industrial injury on 11/14/06. The injured worker reported back pain. The injured worker was diagnosed as having a rotator cuff tear. Treatment to date has included left shoulder rotator cuff repair and Mumford procedure on 1/15/13, right shoulder acromioplasty and Mumford procedure on 10/1/13, a second right shoulder arthroscopy with acromioplasty and Mumford procedure on 4/21/15, physical therapy, a left shoulder injection, and medication including Hydrocodone/APAP, Cyclobenzaprine, Diclofenac Sodium ER, Tramadol HCL ER, and Norco. Currently, the injured worker complains of bilateral shoulder pain at 5/10 on any recent detailed clinical evaluation note of treating physician was not specified in the records. A recent detailed physical examination of the right shoulder was not specified in the records provided. The treating physician requested authorization for a motorized cold therapy unit purchase and a pain pump purchase. The medication list includes Hydrocodone, Diclofen, Pantoprazole, and Cyclobenzaprine. Patient has received an unspecified number of PT visits for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized cold therapy, 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-Treatment in Workers' Compensation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 05/12/15) Heat/cold applications Shoulder (updated 05/04/15) Continuous-flow cryotherapy.

**Decision rationale:** Request: Motorized cold therapy, purchase. Per the cited guidelines "Patients" at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Rationale for not using simple hot/cold packs versus the use of this DME is not specified in the records provided. Per the cited guidelines, "Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders." As per cited guideline, "Continuous-flow cryotherapy: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Motorized cold therapy, purchase is not fully established in this patient.

**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-Treatment in Workers' Compensation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 05/04/15) Postoperative pain pump.

**Decision rationale:** Pain pump, purchase MTUS guideline does not specifically address this issue. Hence, ODG used as per cited guideline, "Postoperative pain pump: Not recommended". Recent studies: Three recent RCTs did not support the use of these pain pumps. This study neither supports nor refutes the use of infusion pumps. 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. The cited guideline do not recommend Postoperative pain pump and pumps did not significantly reduce pain levels. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. Rationale for use of Pain pump, purchase was not specified in the records provided. The medical necessity of the request for Pain pump, purchase is not fully established for this patient.

