

<b>Case Number:</b>	CM13-0034762		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	03/01/2006
<b>Decision Date:</b>	02/03/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine and is licensed to practice in Ohio and Texas. 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 physician 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 patient is a 57-year-old female who reported an injury on 03/01/2006. The mechanisms of injury were not provided in the medical records nor were details of previous courses of treatment. On 05/29/2013, the patient underwent an MRI of the cervical spine for complaints of shoulder pain. The study revealed degenerative disc and facet joint disease with 1 to 2 mm disc protrusions at C3-4, C4-5, and C5-6, and a 2 to 3 mm bulge at the C6-7 level. There were no clinical notes submitted for review documenting the patient's symptoms in regard to her shoulder; however, there is an operative report dated 09/06/2013. On this date, the patient received a right shoulder manipulation under anesthesia, right shoulder diagnostic arthroscopy, extensive synovectomy, chondroplasty glenoid, an arthroscopic subacromial decompression with resection of the CA ligament, injection of glenohumeral joint with lidocaine for postoperative comfort, and a placement of a pain pump to the right shoulder. The reasons for the surgery were diagnoses of right shoulder impingement, right shoulder bicipital tendinitis, and right shoulder adhesive capsulitis. There is no record of any postoperative therapies or other treatments.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A programmable pain pump purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG

**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 California MTUS/ACOEM Guidelines did not address the use of a postoperative pain pump; therefore, the Official Disability Guidelines (ODG) was supplemented. The ODG does not recommend the use of postoperative pain pumps. There is little evidence to conclude that direct infusion is as effective, or more effective, than conventional preoperative or postoperative pain control using oral, intramuscular, or intravenous measures. As such, the request for a programmable pain pump purchase is non-certified.