

<b>Case Number:</b>	CM13-0070052		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	02/06/2008
<b>Decision Date:</b>	05/30/2014	<b>UR Denial Date:</b>	12/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### 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 and is licensed to practice in 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 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 58 year old male who reported an injury on 02/22/2002; the mechanism of injury was not provided within the medical records. The clinical note dated 10/10/2013 noted the injured worker complained of left shoulder pain. The clinical note indicated authorization for left shoulder surgery was received. The injured worker agreed to proceed with the procedure after all risks and benefits were discussed. A discussion was had pertaining to postoperative medications to help control pain and nausea. There was no documentation of a physical exam within the clinical note. A magnetic resonance image (MRI) arthrogram of the left shoulder was done on 05/15/2013. The MRI revealed a full thickness tear involving the supraspinatus tendon at the site of the surgical repair, a partial thickness tear articular surface infraspinatus tendon and a acromioclavicular joint capsular tear with contrast material extravasting into the joint space.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PAIN PUMP PURCHASE FOR LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Procedure Summary -Shoulder, Postoperative Pain Pump.

**Decision rationale:** The Official Disability Guidelines (ODG) state that pain pumps are not recommended. There is insufficient evidence to conclude that direct infusion is as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. The clinical notes addressed the subject of postoperative pain medications with no documentation of a pain pump. It was unclear if the injured worker underwent the surgical intervention to the shoulder or if it was scheduled in the near future. Additionally, the ODG note insufficient evidence to conclude that direct infusion is as or more effective than conventional pre- or postoperative pain control. There was a lack of documentation indicating conventional pre- or postoperative pain control measures would not be adequate. Therefore, the request for a pain pump purchase is not medically necessary and appropriate.