

<b>Case Number:</b>	CM13-0070942		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	05/17/2013
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2013

### 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 and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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:

The patient is a 37 year old with an injury date on 5/17/13. The patient complains of limited range of motion of right shoulder, and difficulty getting hand above shoulder height per 12/3/13 report. Based on the 12/3/13 progress report provided by the treating physician the diagnoses are, right shoulder mild adhesive capsulitis, right shoulder partial rotator cuff tear, bilateral trapezius trigger points, right shoulder impingement syndrome; s/p post-subacromial and right elbow dislocation with flexion contracture and pain along ulnar and radial collateral ligaments. The exam on 12/3/13 showed focal tenderness along biceps tendon, rotator cuff, and subacromial region of right shoulder. Range of motion of right shoulder is 10 degrees less than normal except abduction (155/170 degrees). Positive impingement sign/Neer's test on right shoulder. The treating physician is requesting 2 day pain pump.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**2 DAY PAIN PUMP:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) OFFICIAL DISABILITY GUIDELINES.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain pump SHOULDER:ODG guidelines, shoulder chapter online for: Postoperative pain pump.

**Decision rationale:** This patient presents with right shoulder pain. The treating physician has asked for 2-day pain pump on 12/3/13. Regarding postoperative pain pumps, the ODG shoulder chapter states not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. 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. In this case, the requested 2-day pain pump is not considered medically for this patient. As such, the request is not medically necessary.