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| <b>Case Number:</b>   | CM14-0015290 |                              |            |
| <b>Date Assigned:</b> | 02/28/2014   | <b>Date of Injury:</b>       | 01/06/2012 |
| <b>Decision Date:</b> | 10/10/2014   | <b>UR Denial Date:</b>       | 01/24/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/06/2014 |

### 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 Orthopedic Surgery 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:

This 39-year-old male claimant with an industrial injury dated 01/06/12. MRI of 11/08/12 state there was evidence of supraspinatus tendinosis acromioclavicular joint arthropathy, mild glenohumeral joint effusion, and no obvious abnormalities. Nerve studies dated 11/19/12 states that there was a left ulnar neuropathy proximal to the elbow. Exam note 10/08/13 states the patient is status post left elbow cubital tunnel release with debridement of the flexor tendon origin and partial lateral epicondylectomy with debridement of the extensor tendon origin as of early 2013. The patient states they are satisfied with the surgery results but return with left shoulder pain when fulfilling daily activities. Upon physical exam of the left shoulder there was evidence of tenderness at greater tuberosity, subacromial bursa, and rotator cuff muscle. The patient demonstrated weakness with abduction and external rotation. Also the range of motion was noted as decreased with pain. The patient had a forward flexion of 140', abduction of 130', external rotation of 85', and internal rotation of 15', extension of 25', and adduction of 20'. The patient had lack of full extension of the left elbow, along with decreased strength of flexion and forearm rotation. Treatment includes a cold therapy unit with pain pump with hopes to decrease pain and swelling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SLING:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**Decision rationale:** According to the California MTUS guidelines, Shoulder complaints Chapter 9 pages 212-214, it is recommended to use a brief use of the sling for severe shoulder pain (1-2 days) with pendulum exercises to prevent stiffness and cases of rotator cuff conditions, and prolonged use of the sling only for symptom control is not supported. In this case the use of a shoulder sling would be contraindicated following right shoulder arthroscopy to prevent adhesive capsulitis. The request for a sling is therefore not medically necessary and appropriate.

**COLD THERAPY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous flow cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Continuous flow cryotherapy

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore the request is not medically necessary and appropriate.

**PAIN PUMP:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Postoperative pain pump

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder chapter, postoperative pain pumps 1.)Ciccone WJ 2nd, Busey TD, Weinstein DM, Walden DL, Elias JJ. Assessment of pain relief provided by interscalene regional block and infusion pump after arthroscopic shoulder surgery. Arthroscopy. 2008 Jan;24(1):14-9. 2.)ODG Online edition, 2014. 3.)Matsen FA 3rd, Papadonikolakis A. Published evidence demonstrating the causation of glenohumeral chondrolysis by postoperative infusion of local anesthetic via a pai

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder pain pumps. Per the Official Disability Guidelines, Online edition, Shoulder Chapter, regarding postoperative pain pumps, "Not recommended. 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. " In addition there is concerns regarding chondrolysis in the peer reviewed literature with pain pumps in the shoulder postoperatively. The request is not medically necessary and appropriate.