

<b>Case Number:</b>	CM14-0175943		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	04/25/2010
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Florida. 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 33 year old who was injured on 4/25/2010. The diagnoses are left shoulder pain. The past surgery history is significant for left shoulder arthroscopy, subacromial decompression and acromioplasty. The MRI of the left shoulder from 2011 showed supraspinatus tear and tendinosis. The MRI of the cervical spine showed C5-C6 osteophyte. The patient completed physical therapy and cortisone injections. On 8/29/2014, [REDACTED] indicated that the surgical plan was left shoulder revision arthroscopy with subacromial decompression. On 9/25/2014, [REDACTED] noted objective findings of tenderness over the trapezius and supraspinatus area and positive impingement test of the left shoulder. There was decreased sensation over the C5 and C6 dermatomes. The medication listed is Naprosyn. A Utilization Review determination was rendered on 10/22/2014 recommending non-certification for non-programmable pain pump purchase, Pro-sling with abduction pillow purchase and Q-tech cold therapy recovery system with wrap for home use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Non-programmable pain pump, purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal Drug Delivery Systems (IDDSS).

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

**Decision rationale:** The CA MTUS did not address the use of non-programmable pain pumps for post-operative pain relief. The ODG guidelines recommend that non-programmable pain pump can be utilized following extensive open surgical procedure for patients who met specific indications listed in the guidelines. The records indicate that the request is for 3 days of post-operative use of non-programmable pain pump for pain relief. The pre-operative surgical report indicated that the procedure planned was an arthroscopic revision surgery not an extensive open procedure. The guidelines recommend that many less invasive options can provide adequate pain relief following arthroscopic shoulder surgery. The criteria for the use of non-programmable pain pump purchase were not met.

**Pro-sling with abduction pillow, 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 (ODG), Treatment in Workers Compensation (TWC), Shoulder Procedure Summary, last updated 08/27/2014

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

**Decision rationale:** The CA MTUS did not address the use of post-operative abduction pillow sling. The ODG guidelines recommend that the use of post-operative abduction pillow sling can be beneficial as a treatment option following open rotator cuff repair surgery. The sling and abduction pillow reduces the tension and pressure to the repaired tendon. The abduction pillow sling is not recommended after arthroscopic surgery. The records indicate that the intended surgical procedure is arthroscopic revision surgery not an extensive open procedure. The criteria for the use of post-operative abduction pillow sling were not met.

**Q-tech cold therapy recovery system with wrap, home use:** 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), Treatment in Workers Compensation (TWC), Shoulder Procedure Summary

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

**Decision rationale:** The CA MTUS did not address the use of continuous flow cryotherapy in the post-operative period. The ODG guidelines recommend that continuous flow cryotherapy can be utilized after extensive open joint surgery for a period up to 7 days to decrease pain,

swelling and inflammation. The records indicate that the planned surgery is an arthroscopic revision procedure to the left shoulder not an extensive open joint surgery. The criteria for the use of Q-tech cold therapy recovery system with wrap for home use were not met.