

<b>Case Number:</b>	CM14-0177498		
<b>Date Assigned:</b>	10/30/2014	<b>Date of Injury:</b>	01/26/2012
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 is a 44-year-old female with a 1/26/12 date of injury. The mechanism of injury occurred when she tripped. According to a progress report dated 9/24/14, the patient was doing poorly, with persistent left shoulder pain. The provider has requested authorization to perform a diagnostic and operative arthroscopy of the left shoulder with rotator cuff repair in the past but authorization has not been received. Objective findings: weakness of the left shoulder to external rotation and marked pain with positive impingement signs. Diagnostic impression: clinical and MRI scan evidence of a large full thickness rotator cuff tear of the left shoulder. Treatment to date: medication management, activity modification, physical therapy, and injections. A UR decision dated 10/21/14 denied the requests for 1 shoulder sling, 1 cold therapy unit purchase, and 1 pain pump purchase. It is unclear if the requested surgery was deemed medically necessary. There are contradictory statements in the UR decision in which one statement states that the requested surgery was deemed medically necessary and another stating that the requested surgery has not been deemed as medically necessary. Regarding cold therapy unit, guidelines support up to 7 days use and the duration of use was not provided. Regarding shoulder sling, there is no indication that the patient will undergo open repair of large and massive rotator cuff tears. Regarding pain pump purchase, there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pain control using oral, intramuscular, or intravenous measures.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 Shoulder Sling: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official disability Guidelines Treatment for Workers Compensation, Online Edition Chapter: Shoulder; Immobilization

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

**Decision rationale:** CA MTUS does not address this issue. ODG states that postoperative immobilization is not recommended; immobilization is also a major risk factor for developing adhesive capsulitis, also termed "frozen shoulder". However, in the present case, it is unclear if the requested surgical procedure has been authorized. As a result, this associated postoperative request cannot be substantiated. In addition, a specific rationale as to why a shoulder sling would be required in this patient despite lack of guideline support was not provided. Therefore, the request for 1 Shoulder Sling was not medically necessary.

### **1 Cold Therapy Unit 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 Treatment for Workers Compensation, Online Edition Chapter: Shoulder; continuous - flow cryotherapy

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

**Decision rationale:** CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, in the present case, it is unclear if the requested surgical procedure has been authorized. As a result, this associated postoperative request cannot be substantiated. In addition, guidelines only support up to 7 days postoperative use, and there is no duration specified in this request. Therefore, the request for 1 Cold Therapy Unit Purchase was not medically necessary.

### **1 Pain Pump Purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official disability Guidelines Treatment for Workers Compensation, Online Edition Chapter: Shoulder; Postoperative pain pump

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

**Decision rationale:** CA MTUS does not address this issue. However, ODG does not recommend postoperative pain pumps, with 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. However, in the present case, it is unclear if the requested surgical procedure has been authorized. As a result, this associated postoperative request cannot be substantiated. In addition, there is no documentation as to why this patient cannot tolerate other pain control modalities. A specific rationale as to why a pain pump would be required in this patient despite lack of guideline support was not provided. Therefore, the request for 1 Pain Pump Purchase was not medically necessary.