

<b>Case Number:</b>	CM14-0187355		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	02/19/2011
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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 Fellowship trained in Pediatric Orthopedics, and is licensed to practice in Texas & Colorado. 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 62-year-old female who reported an injury on 02/19/2011 due to an unspecified mechanism of injury. The diagnoses included a rotator cuff tear of the left shoulder. The clinician's note dated 10/01/2014 indicated that the injured worker was doing poorly, with severe pain and weakness to the left shoulder. X-rays of the left shoulder revealed soft tissue swelling and the x-ray of the left hand and wrist revealed no soft tissue. The injured worker was a well-developed, well nurtured female in marked distress. There was severe tenderness about the left shoulder. Prior treatments included physical therapy, medication, injections and rest with a recent placement of a stent. The treatment plan included surgical repair of the rotator cuff. The Request for Authorization was not provided. A rationale was not provided for the pain pump.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Pain pump 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, 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) Shoulder, Postoperative pain pump

**Decision rationale:** The request for associated surgical service pain pump is not medically necessary. The Official Disability Guidelines do not recommend the use of a pump. Three recent moderate quality RCTs did not support the use of pain pumps. Therefore, the studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case studies and poorly designed, randomized, controlled studies with small populations. There is insignificant 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. The documentation was not evident of any functional pain measurements. Additionally, the documentation lacked objective findings to support the need for a pain pump. As such, the request is not medically necessary.