MAXIMUS Federal Services

Case Number:	CM14-0209737		
Date Assigned:	12/22/2014	Date of Injury:	02/21/2014
Decision Date:	02/19/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Washington
Certification(s)/Specialty: Physical Medicine & Rehabn, Pain Management

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 44-year old male who reported an injury on 02/21/2014. The mechanism of injury was a twisting. The injured worker's diagnoses included right rotator cuff tear. The injured worker's past treatments were noted to include physical therapy. The injured worker's diagnostic testing included an MRI of the shoulder without contrast performed on 05/12/2014, read by [redacted], which was noted to reveal supraspinatus tendinosis with fraying/low grade intrasubstance partial thickness tear and subjacent cystic degeneration of the humeral head. Superior subscapularis tendinosis is likewise noted. Degenerative signal transversing the superior labral margin was noted. Mild AC joint hypertrophy with a downsloping acromion abutting the cuff and adjacent scant subacromial deltoid bursal fluid. There were no relevant surgeries included in the documentation. On 10/28/2014, the injured worker complained of right shoulder pain. He denied radiating pain down the right arm. He reported occasionally experiencing popping, clicking, and grinding of the shoulder. He stated that the pain occurred off and on and is increased with attempts at reaching, pushing, pulling, overhead use, and lifting. Upon physical examination, there was pain with palpation of the acromioclavicular joint, subacromial bursa, and subdeltoid bursa on the right. The injured worker was noted with a positive Hawkin's test and impingement sign on the right. The range of motion to the right shoulder was decreased with abduction limited at 60 degrees, flexion at 160 degrees, internal rotation at 50 degrees, external rotation at 75 degrees, and extension at 30 degrees. The injured worker's current medications were not included in the documentation. The request was for pain

pump purchase and IF unit 1-2 month rental. The rationale for the request was not clearly provided. The Request for Authorization form was signed and submitted on 11/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

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)

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 a pain pump purchase is not medically necessary. According to the Official Disability Guidelines, postoperative pain pumps are not recommended. Three recent RCTs did not support the use of these pain pumps. The patient reported right shoulder pain; however, the pain was not quantified. As the request is not supported by the evidence based guidelines, the request is not supported. Therefore, the request is not medically necessary.

IF Unit 1-2 month rental: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 117-120.

Decision rationale: The request for IF unit 1-2 month rental is not medically necessary. According to the California MTUS Guidelines, there is no quality evidence of effectiveness of IF unit except in conjunction with recommended treatments, including return to work, exercise, medications, and limited evidence of improvement on those recommended treatments alone. The documentation does not provide sufficient evidence that the injured worker had pain that was ineffectively controlled due to diminished effectiveness of medications, medication side effects, or history of substance abuse. Documentation did not provide sufficient evidence of a complete and thorough pain assessment (to include least reported pain over period since last assessment, intensity of pain after taking medication, current quantified pain, and how long pain relief lasts). In the absence of documentation with sufficient evidence of tried and failed conservative care (to include physical therapy, a home exercise program, and medications) and a complete and thorough pain assessment, the request is not supported. As such, the request is not medically necessary.