

<b>Case Number:</b>	CM15-0149292		
<b>Date Assigned:</b>	08/12/2015	<b>Date of Injury:</b>	05/01/2008
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	07/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 68-year-old male who sustained an industrial/work injury on 5-1-08. He reported an initial complaint of shoulder pain. The injured worker was diagnosed as having pain in shoulder, shoulder tendinitis-bursitis, sprain and strains of shoulder and upper arm. Treatment to date includes medication, diagnostics, surgery (arthroscopy, extensive synovectomy, chondroplasty of the glenoid, right shoulder labrial repair-decompression, repair of rotator cuff tear on 6-19-15). Currently, the injured worker complained of right shoulder pain with decreased range of motion and strength as well as significant pain in both hips. Per the primary physician's report (PR-2) on 6-15-15, exam notes impingement and Hawkin's of the right shoulder with range of motion, flexion, and abduction less than 100 degrees. Strength of the right deltoid is graded 4 out of 5, hips show tenderness at the greater trochanter bilaterally as well as mild inguinal tenderness bilaterally, crepitus on all planes of motion bilaterally. Shoulder surgery is requested with the post op requested treatments including non-programmable Pain Pump (purchase) and Q-tech Cold Therapy Recovery System with wrap.

### 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:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Pumps.

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

**Decision rationale:** MTUS Guidelines do not address this issue. ODG Guidelines address this issue in detail and the Guideline recommendations are very specific. For the shoulder, a post operative pain pump is not recommended. There are no unusual circumstances to justify an exception to the Guideline recommendations. The Non-programmable Pain Pump (Purchase) is not supported by Guidelines and is not medically necessary.

**Q-tech Cold Therapy Recovery System with wrap x 21 day rental:** 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), Shoulder, Cold Therapy.

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

**Decision rationale:** MTUS Guidelines do not address this issue. ODG Guidelines address this issue in detail and recommend that its post operative use be limited to 7 days. There are no circumstances to justify an exception to the Guideline recommendation. The Q-tech Cold Therapy Recovery System with wrap x 21 day rental is not supported by Guidelines due to the length of the request. Its 21-day rental is not medically necessary.