

Case Number:	CM15-0214839		
Date Assigned:	11/04/2015	Date of Injury:	01/06/2015
Decision Date:	12/16/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	10/30/2015

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: New Jersey
 Certification(s)/Specialty: Family Practice

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 36 year old male who sustained an industrial injury on 1-6-15. The injured worker reported left shoulder pain. A review of the medical records indicates that the injured worker is undergoing treatments for left shoulder pain, left shoulder impingement syndrome, left shoulder strain-sprain and status post left shoulder arthroscopy (7-2-15). Medical records dated 10-13-15 indicate left acromioclavicular joint pain. Provider documentation dated 10-13-15 noted the work status as modified work. Treatment has included status post left shoulder arthroscopy (7-2-15), physical therapy, injection therapy, modified worker duties, transcutaneous electrical nerve stimulation unit, and Norco. Objective findings dated 10-13-15 were notable for left shoulder reduced range of motion, positive left shoulder impingement sign, and tenderness to palpation at left acromioclavicular joint. The original utilization review (10-20-15) denied a request for a Pain Pump X4 Days, Multi-Stim Unit Plus Supplies X3 Months and Continuous Passive Motion (CPM) X6 Weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Pump X4 Days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Implantable drug-delivery systems (IDDSs).

Decision rationale: The MTUS Chronic Pain Treatment Guidelines state that implantable drug-delivery systems are recommended only as an end-stage treatment alternative for selected patients after failure of at least 6 months of less invasive methods, and following a successful temporary trial and for the purpose of facilitating restoration of function and return to activity, and not just for pain reduction. The implantable infusion pump is indicated for malignant pain and also non-malignant pain with documentation of failure of less invasive methods for at least 6 months, intractable pain secondary to a disease state with objective documentation of pathology, further surgical intervention or other treatment is not indicated or likely to be effective, psychological evaluation has been obtained and evaluation states that the pain is not primarily psychologic in origin, no contraindications to implantation (sepsis, coagulopathy, etc.), and a temporary trial of spinal opiates has been successful by at least 50-70% reduction in pain and associated reduction in oral pain medication. An infusion pump trial (rather than spinal injection) may be considered medically necessary only when all other criteria are met. Refill timing for implantable drug-delivery systems will vary based on pump reservoir size, drug concentration, dose, and flow rate. The ODG discusses post-operative pain pumps and states that they are not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Before these studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case series and poorly designed, randomized, controlled studies with small populations. There is 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. In the case of this worker, the provider requested surgery (open distal clavicle resection of the left shoulder) followed by post-op pain pump for 4 days. According to the most recent studies, this form of pain treatment is no better than other less invasive methods and therefore is not medically necessary.

Multi-Stim Unit Plus Supplies X3 Months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: A Multi-Stim device has both interferential current stimulation and neuromuscular stimulation. The MTUS Chronic Pain Treatment Guidelines state that neuromuscular stimulation is not recommended. It is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from neuromuscular stimulation for chronic pain. Also, The MTUS Chronic Pain Guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention as there is no quality evidence. It may be considered as an adjunct if used in

conjunction with recommended treatments, including return to work, exercise, and medications if these have not shown to provide significant improvements in function and pain relief, and has already been applied by the physician or physical therapist with evidence of effectiveness in the patient. Criteria for consideration would include if the patient's pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, if the patient has a history of substance abuse, if the patient has significant pain from postoperative conditions which limits the ability to perform exercise programs or physical therapy treatments, or if the patient was unresponsive to conservative measures (repositioning, heat/ice, etc.). A one month trial may be appropriate if one of these criteria are met as long as there is documented evidence of functional improvement and less pain and evidence of medication reduction during the trial period. Continuation of the ICS may only be continued if this documentation of effectiveness is provided. Also, a jacket for ICS should only be considered for those patients who cannot apply the pads alone or with the help of another available person, and this be documented. In the case of this worker, there was a request for Multi-stim, which is not necessary over a device which uses only one mode of transcutaneous stimulation. Also, even if one mode would be used this request for the Multi-stim device suggested one for purchase and a rental/trial would need to precede any request for purchase, all of which is not likely to be necessary following a surgical procedure. Therefore, this request for Multi-stim and supplies are not medically necessary.

Continuous Passive Motion (CPM) X6 Weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Continuous passive motion (CPM).

Decision rationale: The MTUS Guidelines are silent on the subject of continuous passive motion devices for postoperative use in the shoulder. The ODG, however, states that it is not recommended for shoulder rotator cuff problems, but may be considered as an option for adhesive capsulitis up to 4-5 days per week as it has shown to decrease pain. In the case of this worker, there was no listed diagnosis or signs suggestive of adhesive capsulitis to warrant this request for continuous passive motion. Therefore, this request seems inappropriate and is not medically necessary.