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| Case Number: | CM15-0034347 | | |
| Date Assigned: | 03/02/2015 | Date of Injury: | 01/14/2013 |
| Decision Date: | 04/14/2015 | UR Denial Date: | 01/27/2015 |
| Priority: | Standard | Application Received: | 02/23/2015 |

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: Physical Medicine & Rehabilitation

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 50-year-old male, who sustained an industrial injury on January 14, 2013. He has reported a lifting injury. The diagnoses have included right shoulder labral tear with anterior instability and impingement. Treatment to date has included acupuncture, TENS unit, diagnostic studies, chiropractic treatment and medications. On January 12, 2015, the injured worker complained of increasing pain to his right shoulder along with popping. He reported feeling a pop in his lower back a few weeks prior to evaluation. Physical examination revealed decreased range of motion of the right shoulder, weakness to right shoulder abduction and external rotation and evidence of anterior instability. There was a positive relocation test and positive impingement sign. He stated that he was using a TENS unit and topical creams which were helping him out. On January 27, 2015 Utilization Review non-certified a purchase of a pain pump, noting the CA MTUS and Official Disability Guidelines. On February 23, 2015, the injured worker submitted an application for Independent Medical Review for review of purchase of a pain pump.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of pain pump: 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-TWC) Chapter: Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter, Postoperative pain pump.

Decision rationale: The patient presents with pain and weakness in his right shoulder and lower back. The request is for purchase of pain pump. The patient has had TENS unit, medications, acupuncture, chiropractic treatment in the past. Work status is not known. ODG guidelines, shoulder chapter online for: Postoperative pain pump, states: "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. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically, shoulder and knee procedures." In this case, the treater requested for pain pump as post-op treatment. The use of a pain pump for shoulder procedures is not in accordance with ODG guidelines. Furthermore, the requested right shoulder arthroscopy was not deemed medically necessary per the utilization review letter on 01/27/15. The request IS NOT medically necessary.