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| Case Number: | CM15-0238467 | | |
| Date Assigned: | 12/15/2015 | Date of Injury: | 12/18/2014 |
| Decision Date: | 01/15/2016 | UR Denial Date: | 11/24/2015 |
| Priority: | Standard | Application Received: | 12/07/2015 |

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 47 year old male, who sustained an industrial injury on 12-18-2014. The injured worker was diagnosed as having a large glenoid labral tear, or SLAP tear, of the right shoulder. Treatment to date has included diagnostics, physical therapy, injections, rest, and medications. On 10-28-2015, the injured worker complains of marked locking of his right shoulder and "doing poorly". Exam noted severe tenderness about his right shoulder, positive O'Brien test, consistent with a SLAP tear. Magnetic resonance imaging of the right shoulder was documented as showing a large SLAP tear (report submitted from exam date 10-15-2015). His current work status was not specified, noting full duty on 9-30-2015. The treatment plan included arthroscopy, right shoulder SLAP repairs possible acromioplasty, Mumford, Biceps Tenodesis, sutures anchors, and associated services that included pain pump purchase and indefinite use of cold therapy unit. On 11-24-2015 Utilization Review non-certified pain pump purchase and modified indefinite use of cold therapy unit to cold therapy rental unit x7 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Services: Pain pump, purchase, Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG): Shoulder - Post operative Pain Pump.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, postoperative pain pumps and Other Medical Treatment Guidelines 1.) Ciccone WJ 2nd, Busey TD, Weinstein DM, Walden DL, Elias JJ. Assessment of pain relief provided by interscalene regional block and infusion pump after arthroscopic shoulder surgery. *Arthroscopy*. 2008 Jan; 24 (1): 14-9. 2.) Official Disability Guidelines (ODG) Online edition, 2014. 3.) Matsen FA 3rd, Papadonikolakis A. Published evidence demonstrating the causation of glenohumeral chondrolysis by postoperative infusion of local anesthetic via a pain pump. *J Bone Joint Surg Am*. 2013 Jun 19; 95 (12): 1126-34.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder pain pumps. Per the Official Disability Guidelines, Online edition, Shoulder Chapter, regarding postoperative pain pumps, 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. In addition there is concerns regarding chondrolysis in the peer reviewed literature with pain pumps in the shoulder postoperatively. As the guidelines and peer reviewed literature does not recommend pain pumps, the use of a pain pump in this case is not medically necessary.

Associated Surgical Services: Cold therapy unit, indefinite use, Qty 1: 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.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of cold compression therapy. According to the ODG, Shoulder / Cold compression therapy, it is not recommended in the shoulder as there are no published studies. It may be an option for other body parts such as the knee although randomized controlled trials have yet to demonstrate efficacy. In this case review of the records from 10/28/15 show that the proposed surgery is a shoulder arthroscopy. As the guidelines do not recommend the requested DME, the shoulder cold compression therapy is not medically necessary.