MAXIMUS Federal Services

Case Number:	CM14-0143183		
Date Assigned:	09/10/2014	Date of Injury:	05/08/2013
Decision Date:	10/14/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	09/04/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 55-year-old female who reported an injury on 05/08/2013. The injury reportedly occurred when she was placing sheets on a bed from 1 of the rooms when she noted some discomfort in her right shoulder. Her diagnoses included impingement of the right shoulder and partial rotator cuff tear. Her past treatments were noted to include medications, physical therapy, and a right shoulder surgery approximately 14 years ago. There were no relevant diagnostic studies noted. The injured worker's surgical history included a right shoulder arthroscopy dated 08/08/2014. On 07/09/2014, the injured worker complained of continued pain to the right shoulder. She reported that she had moderate shoulder limitation. Upon physical examination, she was noted to have decreased range of motion to the right shoulder with abduction limited to 80 degrees, forward flexion to 100 degrees, and extension to 20 degrees. The injured worker's relevant medications were noted as gabapentin, tramadol, and naproxen. The treatment plan was to have a shoulder arthroscopy with release of adhesions. A request was received for a pain pump. The rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: 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), Shoulder Procedure Summary

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 is not medically necessary. The Official Disability Guidelines do not recommend postoperative pain pumps. There is insufficient evidence to conclude that direct fusion is as effective as or more effective than conventional pre or postoperative pain control using oral, intramuscular, or intravenous measures. The injured worker did undergo a right shoulder arthroscopy, however, the use of a postoperative pain pump is not recommended per the guidelines. There was no documentation with evidence that the injured worker's pain could not be controlled by oral pain medication. Given this information, the request is not supported at this time. Therefore, the request is not medically necessary.