

Case Number:	CM14-0157677		
Date Assigned:	09/30/2014	Date of Injury:	07/01/2013
Decision Date:	10/29/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/25/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 36 year old man who sustained a work-related injury on July 1, 2013. Subsequently he developed with chronic left shoulder pain. According to a note dated on August 20, 2014, the patient was complaining to of severe left shoulder pain. His physical examination demonstrated the market weakness of the left shoulder external rotation and a positive impingement sign. X-ray of left shoulder showed spurring of the undersurface of the acromion. His MRI demonstrated significant high grade thickness of the rotator cuff of the left shoulder. The provider requested authorization for pain pump.

IMR ISSUES, DECISIONS AND RATIONALES

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

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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs) Page(s): 52.

Decision rationale: My rationale for why the requested treatment/service is or is not medically necessary: According to MTUS guidelines, Implantable drug-delivery systems (IDDSs) is recommended only as an end-stage treatment alternative for selected patients for specific

conditions indicated below (Cancer conditions), after failure of at least 6 months of less invasive methods, and following a successful temporary trial. There is no documentation of type of medications prescribed through neither the pump nor the concentration, dose and flow rate. There is no documentation for the rational of using a pump rather than oral or transdermal drug administration. Therefore, the request for Pain Pump is not medically necessary.