

<b>Case Number:</b>	CM14-0211619		
<b>Date Assigned:</b>	12/24/2014	<b>Date of Injury:</b>	01/04/2012
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2014

### 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. 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: 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:

According to the records made available for review, this is a 57-year-old male with a 1/4/12 date of injury. At the time (11/3/14) of request for authorization for Pain pump, Cold therapy unit, and IF unit 1-2 month rental, there is documentation of subjective (right shoulder pain with catching and locking) and objective (positive O-Brien's test) findings, current diagnoses (large SLAP tear of the right shoulder), and treatment to date (medications and physical therapy). Medical report identifies that there is a right shoulder SLAP repair which has been authorized/certified. Regarding IF unit 1-2 month rental, there is no documentation that the interferential stimulator unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone.

### 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 cite any medical evidence for its decision.

**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:** MTUS does not address this issue. ODG identifies that post-operative pain pump is not recommended and that 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 measure. Therefore, based on guidelines and a review of the evidence, the request for Pain pump is not medically necessary.

**Cold Therapy Unit:** 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 Chapter, Continuous-flow cryotherapy.

**Decision rationale:** MTUS does not address this issue. ODG identifies continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. Within the medical information available for review, there is documentation of a diagnosis of large SLAP tear of the right shoulder. In addition, there is documentation of a right shoulder SLAP repair which is authorized/certified. However, there is no documentation of the duration of use of the requested. Therefore, based on guidelines and a review of the evidence, the request for Cold Therapy Unit is not medically necessary.

**IF Unit 1-2 month rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the medical information available for review, there is documentation of a diagnosis of large SLAP tear of the right shoulder. In addition, there is documentation of a right shoulder SLAP repair which is authorized/certified. However, there is no documentation that the interferential stimulator unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Therefore, based on

guidelines and a review of the evidence, the request for IF Unit 1-2 month rental is not medically necessary.