

<b>Case Number:</b>	CM15-0006810		
<b>Date Assigned:</b>	01/22/2015	<b>Date of Injury:</b>	12/01/2008
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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: Minnesota, Florida  
 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 56 year old female, who sustained an industrial injury on December 1, 2008. She has reported a low back injury and twisting injuries to her shoulders and neck. Diagnoses have included a near full thickness rotator cuff tear with impingement syndrome. Treatment to date has included MRI, physical therapy and topical pain medications. On November 20, 2014, the treating physician noted persistent right shoulder pain with difficulty raising the arm. The physical exam revealed right shoulder weakness, positive impingement sign, and positive Neer and Hawkin's signs. The physician noted an MRI of the right shoulder revealed a near full thickness rotator cuff tear with severe impingement. A request for arthroscopy of the shoulder with rotator cuff repair, suture anchors and screw, and Mumford procedure was certified by utilization review. Post operative cryotherapy, sling, and physical therapy were also certified. Additional requests for an interferential unit and pain pump were noncertified. On January 13, 2015, the injured worker submitted an application for IMR for review of requests pain pump and interferential unit. The pain pump was non-certified based on short-term use of narcotic and/or non-steroidal anti-inflammatory medications should suffice for pain control. The interferential unit was non-certified based on lack of quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. The California Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG) were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-Op 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Section: Shoulder, Topic: Postoperative Pain Pump

**Decision rationale:** ODG guidelines do not recommend a post-operative pain pump after shoulder surgery. Three recent moderate quality randomized clinical trials did not support the use of pain pumps. As such, the request for a post-operative pain pump is not supported and the medical necessity is not established.

**Post-Op DME: IF 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)

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

**Decision rationale:** The guidelines do not recommend interferential current stimulation as an isolated application. Even in conjunction with other recommended treatments there was limited evidence of improvement. The randomized clinical trials included the use for shoulder pain and the results were either negative or non-interpretable. As such the request for Post-operative DME: IF Unit is not supported and the medical necessity is not established.