Case Number:	CM15-0112508		
Date Assigned:	06/19/2015	**Date of Injury:**	09/17/2014
Decision Date:	07/17/2015	**UR Denial Date:**	06/02/2015
Priority:	Standard	**Application Received:**	06/11/2015

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
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 30-year-old male who sustained an industrial injury on 09/17/2014. Mechanism of injury was not documented. Diagnoses include a near full thickness tear of the rotator cuff of the right shoulder. Treatment to date has included diagnostic studies, medications, physical therapy and injections. There is an unofficial right shoulder Magnetic Resonance Imaging showed a near full thickness tear of the rotator cuff. A physician progress note dated 05/11/2015 documents the injured worker is having progressive pain and instability of his right shoulder. He has tenderness about his right shoulder with a positive O'Brien's test, suggestive of biceps tendon subluxation, as well as a positive Neer & Hawkins impingement sign. The treatment plan includes an Acromioplasty, assistant PA, biceps tendon tenodesis, diagnostic and operatic arthroscopy of the right shoulder, Labs for medical clearance (CBC, BMP, physical therapy PT/PTT, and UA, Mumford procedure, PASTA repair, Post-op physical therapy 3x4 to the right shoulder and a shoulder sling. Treatment requested is for Cold therapy unit (purchase), IF Unit (30 day rental), and Pain pump (purchase).

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain pump (purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

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

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 concern 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 request is not medically necessary.

IF Unit (30 day rental): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, "Not recommended as an isolated intervention. 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues." As there is insufficient medical evidence regarding use in this clinical scenario from the exam note of 5/11/15, request is not medically necessary.

Cold therapy unit (purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Continuous flow cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, the request has an unspecified number of days. Therefore, the request is not medically necessary.