

<b>Case Number:</b>	CM15-0117824		
<b>Date Assigned:</b>	07/06/2015	<b>Date of Injury:</b>	05/27/2014
<b>Decision Date:</b>	09/15/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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, Oregon, Washington  
 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:

This injured worker is a 33 year old male who reported an industrial injury on 5-27-2014. His diagnoses, and or impression, were noted to include: right shoulder dislocation with right shoulder arthroscopy, decompression and labral repair (8-16-14); post-operative adhesive capsulitis with manipulation under anesthesia (1-24-15); and seizure disorder. No current imaging studies were noted. His treatments were noted to include: an agreed medical evaluation in 2-2015; surgery; physical therapy; injection therapy; medication management; and rest from work. The progress notes of 5-5-2015 reported a follow-up visit for post-operative adhesive capsulitis and manipulation under anesthesia (1-24-15). Objective findings were noted to include: no acute distress; diffuse tenderness over the shoulder, with restricted range-of-motion and decreased motor strength; right shoulder pain following failed extensive treatments including therapy, anti-inflammatories, post-operative injection, and manipulation under anesthesia; and the request for additional surgery. The physician's requests for treatments were noted to include right shoulder arthroscopy with capsular release and subacromial decompression.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Pain pump x 48 hours: 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 chapter.

**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 are concerns 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 determination is for non-certification. 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. The above request is not medically necessary.

**Associated surgical service: Cold therapy unit x 14 days:** 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 chapter.

**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 post-operatively for upwards of 7 days. In this case the requested days post-operatively for the cryotherapy unit exceeds this maximum of 7 days. Therefore the request is not medically necessary.