

<b>Case Number:</b>	CM15-0077448		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	09/24/2014
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2015

### 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 46 year old female, who sustained an industrial injury on September 24, 2014. The injured worker has been treated for neck, right shoulder, bilateral elbows and hand complaints. The diagnoses have included right shoulder impingement, sprain/strain of other specified sites of shoulder and upper arm, bilateral lateral epicondylitis, bilateral trapezius strain, right shoulder superior labrum anterior to posterior tear and cervical degenerative joint disease. Treatment to date has included medications, radiological studies, physical therapy, heat/ice treatment, a shoulder injection and a home exercise program. Current documentation dated February 12, 2015 notes that the injured worker reported right shoulder and bilateral elbow pain. The injured worker noted that she had a shoulder injection performed without significant improvement. Examination of the right shoulder revealed tenderness to palpation over the trapezius muscles extending from the shoulder to the occiput of the skull. A Neer's test, Hawkins's test and a supraspinatus empty can test were positive. Examination of the bilateral elbows revealed moderate tenderness over the lateral epicondyles. The treating physician's plan of care included surgery and a request for a pre-operative shoulder x-ray, pre-operative MRI of the shoulder and post-operative pain pump, infinite use. The surgery was certified along with multiple other requests. However, the x-ray and MRI and pain pump requests were non-certified. CA MTUS and ODG guidelines were cited. These have been appealed to an independent medical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre operative shoulder x-ray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

**Decision rationale:** California MTUS guidelines indicate that the primary criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction such as weakness from a massive rotator cuff tear, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure, for example a full-thickness rotator cuff tear not responding to conservative treatment. The documentation provided indicates that MRI scan of the shoulder has already been done and the diagnosis confirmed. There is no indication for a repeat study as the subjective and objective findings have not changed. As such, the request for a shoulder x-ray and MRI is not supported and the medical necessity of the request has not been substantiated. Therefore, the requested medical treatment is not medically necessary.

**Pre-operative MRI of the shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

**Decision rationale:** California MTUS guidelines indicate that the primary reasons for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction such as weakness from a massive rotator cuff tear, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure, for example a full-thickness rotator cuff tear not responding to conservative treatment. The documentation provided indicates that MRI scan of the shoulder has already been done and the diagnosis confirmed. There is no indication for a repeat study as the subjective and objective findings have not changed. As such, the request for a repeat shoulder MRI is not supported and the medical necessity of the request has not been substantiated. Therefore, the requested medical treatment is not medically necessary.

**Post-operative DME; Pain pump (infinite use):** 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 Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: shoulder, Topic: Postoperative pain pumps.

**Decision rationale:** ODG guidelines do not recommend postoperative pain pumps after shoulder surgery. 3 recent randomized controlled trials did not support the use of these pain pumps. Another study concluded that infusion pumps did not significantly reduce pain levels. A small case series also reported incidence of glenohumeral chondrolysis associated with the use of intra-articular pain pump catheters. As such, the request for a pain pump is not supported by evidence-based guidelines and the medical necessity of the request has not been substantiated. Therefore, the requested medical treatment is not medically necessary.