

<b>Case Number:</b>	CM15-0099370		
<b>Date Assigned:</b>	06/01/2015	<b>Date of Injury:</b>	12/21/2010
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2015

### 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: Physical Medicine & Rehabilitation

### 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 67 year old male who sustained an industrial injury on 12/21/2010. Current diagnoses include near full thickness tear of the rotator cuff with impingement syndrome and acromioclavicular joint degenerative changes. Previous treatments included medication management, right shoulder surgery on 02/11/2014, physical therapy, and injections. Previous diagnostic studies include a MRI of the left shoulder dated 03/31/2015. Report dated 04/20/2015 noted that the injured worker presented with complaints that included weakness of the left shoulder. Physical examination was positive for global tenderness in the left shoulder with positive impingement sign. MRI of the left shoulder revealed a near full thickness tear of the rotator cuff with impingement syndrome and acromioclavicular joint degenerative changes. The treatment plan included agreement with the AME that the injured worker requires arthroscopic surgery of the left shoulder. Disputed treatments include post-operative pain pump (purchase), post-operative interferential (IF) unit (30 day rental), and cold therapy unit for the left shoulder (purchase).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative pain pump purchase:** 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 (Online version).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter: Postoperative pain pump.

**Decision rationale:** According to the 02/02/2015 report, this patient is doing better with regard to his bilateral shoulders, bilateral hands and wrists, and low back, but continues to complain of severe left ankle pain. The current request is for Post-operative pain pump purchase but the treating physician's report containing the request is not included in the file. The most recent progress report is dated 02/02/2015 and the utilization review letter in question is from 05/15/2015. The request for authorization is on 05/08/2015 and the patient's work status is not included in the file for review. The Utilization Review denial letter states. "The guidelines specifically do not recommend postoperative pain pump for the shoulder." Regarding post-operative pain pump for the shoulder, ODG guidelines states "Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps." The requested pain pump is not in accordance with the guidelines; therefore, the current request IS NOT medically necessary.

**Post-operative Interferential (IF) Unit for 30 day rental:** Overturned

**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 unit Page(s): 118-120.

**Decision rationale:** According to the 02/02/2015 report, this patient is doing better with regard to his bilateral shoulders, bilateral hands and wrists, and low back, but continues to complain of severe left ankle pain. The current request is for Post-operative Interferential (IF) Unit for 30 day rental but the treating physician's report containing the request is not included in the file. The most recent progress report is dated 02/02/2015 and the utilization review letter in question is from 05/15/2015. The request for authorization is on 05/08/2015 and the patient's work status is not included in the file for review. The Utilization Review denial letter states. "The evidence-based guidelines do not provide evidence to support the medical necessity for IF unit rental following shoulder surgery." The MTUS Guidelines page 118 to 120 states that interferential current stimulation is not recommended as an isolated intervention. MTUS also recommends trying the unit for one-month before a home unit is provided if indicated. Indications are pain ineffectively controlled with medication; history of substance abuse; post-operative use; unresponsive to conservative measures. Review of the provided reports show no discussion of return to work, exercise or medications. It appears that the request is to address the patient's post-operative pain. The request is for a 30 day rental and appears reasonable. It is consistent with MTUS. The request IS medically necessary.

**Associated surgical service: cold therapy unit for left shoulder purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Shoulder Chapter (Online version).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter: continuous-flow cryotherapy.

**Decision rationale:** According to the 02/02/2015 report, this patient is doing better with regard to his bilateral shoulders, bilateral hands and wrists, and low back, but continues to complain of severe left ankle pain. The current request is for Associated surgical service: cold therapy unit for left shoulder purchase but the treating physician's report containing the request is not included in the file. The most recent progress report is dated 02/02/2015 and the utilization review letter in question is from 05/15/2015. The request for authorization is on 05/08/2015 and the patient's work status is not included in the file for review. Regarding cold therapy, ODG guidelines "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Review of the provided reports does not show that the patient had surgeries to the left shoulder recently. The use of Cold Therapy System is recommended as an option after surgery, but not for nonsurgical treatment. Furthermore, it is recommended only for 7 day use and the current request does not specify how many days. The request IS NOT medically necessary.