

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/17/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/30/2013
Date of Injury:	7/17/2012
IMR Application Received:	8/9/2013
MAXIMUS Case Number:	CM13-0009559

- 1) MAXIMUS Federal Services, Inc. has determined the request for **postoperative pain pump for the shoulder is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/9/2013 disputing the Utilization Review Denial dated 7/30/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **postoperative pain pump for the shoulder is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

This is a 50-year-old female injured on 7/17/12 sustaining injury to the left shoulder. The clinical records indicate that following a course of care to the shoulder the claimant was scheduled and certified by the carrier to undergo a left shoulder diagnostic operative arthroscopy and debridement with acromioplasty, resection of coracoacromial ligament, bursectomy, and distal clavicle resection with rotator cuff repair procedure. A 7/23/13 report indicates the need for use of a pain pump in the post-operative setting. This request was denied and not certified by utilization review on 7/30/13 citing lack of long term randomized clinical trials to support the use of pain pump as an effective and more cost-effective form of perioperative pain control. Further records are not indicated in this case. There is, once again, a request for the use of a pain pump in the post-operative setting from a clinical report dated 7/23/13.

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:



- 1) **Regarding the request for postoperative pain pump for the shoulder:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Shoulder, Postoperative Pain Pump, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Shoulder procedure, Post-operative pain pump, which is not part of the MTUS.

Rationale for the Decision:

Based on the medical records provided for review this is employee was injured on 7/17/12 sustaining an injury to the left shoulder. The clinical records indicate following a course of care to the shoulder the employee was scheduled and certified by the carrier to undergo a left shoulder diagnostic operative arthroscopy and debridement with acromioplasty, resection of coracoacromial ligament, bursectomy, and distal clavicle resection with rotator cuff repair procedure. A 7/23/13 report indicates the need for use of a pain pump in the post-operative setting. The Official Disability Guidelines indicate that pain pumps following shoulder procedures are "not recommended" citing lack of randomized clinical trials to support their long term efficacy and benefit. The use of a pain pump device for the shoulder in the post-operative setting would not be supported. **The request for postoperative pain pump for the shoulder is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.