

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW: OCTOBER 10, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Post-surgical pain pump for the left shoulder.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notes, 05/23/07, 06/06/07 and 07/25/07
Left shoulder MRI, 05/29/07
Adverse Determination Letters, 08/10/07 and 08/22/07
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Shoulder
Postoperative pain pump

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a apparently injured in a motor vehicle accident. He was treated for back pain and left shoulder pain and diagnosed with left shoulder impingement. MRI on 05/29/07 noted a supraspinatus tear with fluid in the subacromial and subdeltoid bursa indicating a full thickness tear. Also noted was an oblique tear superior to the glenoid labrum and spur formation of the acromioclavicular joint causing impingement on the supraspinatus muscle tendon junction. An office note on 07/25/07 indicated the claimant would proceed with left shoulder surgery for repair of a full thickness rotator cuff tear. A

postoperative pain pump was requested and non-certified on two separate reviews. An appeal of that decision was requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

I agree with the determination of the insurance carrier in this case. A post surgical pain pump following left shoulder surgery is not recommended as medically necessary.

The claimant, a male, apparently sustained injuries in a motor vehicle accident. The records reviewed indicate left shoulder surgery is a consideration and a postoperative pain pump was requested. In general, there is no evidence in peer-reviewed literature to support the medical necessity of the use of a pain pump for post operative pain complaints. Post operative pain can be managed effectively with oral analgesics. There is no documentation provided to support that this patient would be an exception to the standards of care. According to the Official Disability Guidelines, there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Shoulder Postoperative pain pump

Under study. Evidence supporting the use of ambulatory pain pumps exists primarily in the form of small case series and poorly designed, randomized, controlled studies with small populations. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically, shoulder and knee procedures. A surgeon will insert a temporary, easily removable catheter into the shoulder joint that is connected to an automatic pump filled with anesthetic solution. This "pain pump" may help considerably with postoperative discomfort, and is removed by the patient or their family 2 or 3 days after surgery. A review of the published, peer-reviewed scientific literature yields insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. (Barber, 2002) (Quick, 2003) (Harvey, 2004) (Cigna, 2005) (Cho, 2007)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)