

<b>Case Number:</b>	CM14-0192089		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	08/10/2000
<b>Decision Date:</b>	01/12/2015	<b>UR Denial Date:</b>	10/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas and Virginia. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 59-year-old female who reported an injury on 08/10/2000. The injured worker reportedly suffered a left shoulder strain while transferring a client. The current diagnoses include left shoulder labral tear, and possible rotator cuff tear, acromioclavicular arthritis, and bicep tendinitis. A Request for Authorization form was submitted on 10/24/2014 for a left shoulder arthroscopy with postoperative medication, postoperative follow-up visits, and postoperative durable medical equipment. The injured worker presented on 09/15/2014 with complaints of persistent left shoulder pain. It is noted that the injured worker has been previously treated with medications and an intra-articular steroid injection. Physical examination revealed full shoulder range of motion, AC joint tenderness, lateral subacromial tenderness, positive impingement test, positive apprehension test, and 2+ instability. Treatment recommendations included a left shoulder arthroscopy. It is noted that the injured worker was issued authorization for a left shoulder arthroscopy with debridement, possible labral tear, possible rotator cuff repair, possible bicep tenodesis, subacromial decompression and distal clavicle resection on 10/29/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated Surgical Service: Norco, 10-325 mg #60 1 refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Norco, short-acting opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the injured worker has been issued authorization for a left shoulder arthroscopic procedure. The medical necessity for postoperative pain medication has been established. However, there is no frequency listed in the current request. The medical necessity for an additional refill has not been established. Therefore, the request is not medically appropriate.

**Associated Surgical Service: Naproxen 550 mg #60 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line option after acetaminophen. The medical necessity for postoperative Naproxen 550 mg has been established. However, there is no frequency listed in the current request. Additionally, the medical necessity for an additional refill has not been established. As such, the request is not medically appropriate.

**Associated Surgical Service: Zofran 8 mg #10:** 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), Pain (Chronic) Chapter, Antiemetics

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Ondansetron, Antiemetic

**Decision rationale:** The Official Disability Guidelines state Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. It has been recommended for nausea and vomiting secondary to chemotherapy and radiation treatment, and is also FDA approved for postoperative use. The injured worker has been issued authorization for a left shoulder arthroscopic procedure. Therefore, the medical necessity for postoperative Zofran 8 mg has been established. However, there is no frequency listed in the request. As such, the request is not medically appropriate.

**Associated Surgical Service: Colace 100 mg #20: 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), Pain (Chronic) Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Opioid induced constipation treatment.

**Decision rationale:** California MTUS Guidelines recommend initiating prophylactic treatment of constipation when also initiating opioid therapy. The Official Disability Guidelines state opioid induced constipation treatment includes maintaining appropriate hydration, advising the patient to follow a proper diet, and increasing physical activity. The medical necessity for the requested medication has not been established. There is also no frequency listed in the current request. As such, the request is not medically appropriate.

**Associated Surgical Service: 4 Postoperative Office Visits (within global period with fluoroscopy): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Postoperative office visits

**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, Office Visit.

**Decision rationale:** The Official Disability Guidelines state the need for an office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability and reasonable physician judgment. It is unclear as to why fluoroscopy would be required. Postoperative x-rays and/or fluoroscopy are not routine following the requested procedure. The medical necessity for 4 postoperative visits has not been established. Therefore, the request is not medically appropriate.

**Associated Surgical Service: DME: 2-Week Rental of Game Ready Unit: 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 (Acute and Chronic) Chapter, Cold compression therapy

**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, Continuous flow cryotherapy

**Decision rationale:** The Official Disability Guidelines recommend continuous-flow cryotherapy following surgery, for up to 7 days, including home use. The current request for a 2 week rental exceeds guideline recommendations. As such, the request is not medically appropriate.