

<b>Case Number:</b>	CM15-0105123		
<b>Date Assigned:</b>	06/12/2015	<b>Date of Injury:</b>	12/19/2011
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: 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 a 56-year-old male, with a reported date of injury of 09/01/2011. The diagnoses include multilevel lumbar disc desiccation and bulging with spondylosis, and right shoulder impingement syndrome with acromioclavicular joint pain. Treatments to date have included oral medications and an MRI of the lumbar spine on 05/22/2012 which showed diffuse disc protrusion effacing the thecal case, and bilateral neural foraminal narrowing. The progress report dated 04/21/2015 indicates that the injured worker complained of a stabbing pain in the head, aching neck and bilateral shoulder pain, stabbing upper back, mid back, and lower back pain, and pin and needle sensations in the bilateral arms and hands. The objective findings include a normal gait, tenderness of the right anterior and lateral deltoid, positive right shoulder impingement sign, tenderness of the right acromioclavicular joint, tenderness of the right biceps tendon, right shoulder abduction at 160 degrees, right internal rotation at 90 degrees, right shoulder flexion at 165 degrees, right shoulder adduction at 40 degrees, tenderness about the lumbar paraspinal muscles, muscle spasm with motion of the lumbar spine, lumbar spine flexion at 30 degrees, and lumbar extension at 40 degrees. The treating physician requested right shoulder arthroscopic subacromial decompression and Mumford procedure; post-operative physical therapy for the right shoulder; motorized hot/cold unit; Pro-sling with abduction pillow; pre-operative clearance; an MRI of the lumbar spine; Tramadol ER 150mg #60; and Zolpidem 10mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopic subacromial decompression and Mumford procedure:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG (Shoulder Chapter); Gregory N Levick, MD Direct Arthroscopic Distal Clavicle Resection. Iowa Orthop J. 149-156.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty surgery.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 4/21/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 4/21/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is not medically necessary.

**Post-operative physical therapy for the right shoulder 2x4:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Motorized hot/cold unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Pro-Sling with abduction pillow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-op clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: MRI of lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Occupational Medicine Practice Guidelines, 2nd edition, pages 700-707.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** According to CA MTUS/(ACOEM), 2nd edition (2004), page 303, Low Back Complaints, Chapter 12, which is part of the California Medical Treatment Utilization Schedule. It states, unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). In this particular patient there is no indication of criteria for an MRI based upon physician documentation or physical examination findings from the exam note of 4/21/15. There is no documentation nerve root dysfunction or failure of a treatment program such as physical therapy. Therefore the request of the MRI of the lumbar spine is not medically necessary.

**Tramadol ER 150mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Zolpidem 10mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of Ambien. According to the ODG, Pain Section, Zolpidem (Ambien) is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. There is no evidence in the records from 4/21/15 of industrial related insomnia to warrant Ambien. Therefore the determination is not medically necessary.