

<b>Case Number:</b>	CM15-0018455		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	09/19/2008
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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 (IW) is a 49-year-old male who sustained an industrial injury on 09/19/2008. He has reported left shoulder pain. Diagnoses include strain/sprain of the cervical spine, and traumatic arthropathy involving shoulder region. Treatment to date includes medications and electrical stimulation. A progress note from 11/10/14 was the latest provider records available for UR review and it notes the Injured Worker underwent right shoulder corticosteroid injection at the prior appointment that provided him with some relief. On examination, his left shoulder had crepitus in the glenohumeral joint; his forward elevation was 80 degrees, external rotation 20 degrees, and internal rotation to L5. MRI revealed marked glenohumeral osteoarthritis, greater posterior/inferior, no rotator cuff tear, distal supraspinatus tenderness, no subacromial effusion and slight spurring at the acromioclavicular joint with a type 1 acromion. The treating provider notes dated 01/14/2015 indicates the cervical spine range of motion was limited with pain at the end point of movement. Severe spasms and decreased rotation were noted in the left trapezius and left scalene. There was decreased sensation C5-C7 dermatome distribution in the left upper extremity. Right upper arm strength was 3/5. Grip on the right was decreased. The plan of treatment included having the Injured Worker attend a C-spine consultation to assess for the authorized cervical fusion; prescriptions were given for Oxycontin 40 mg, Norco 10/325, Gabapentin 600, Ibuprofen 800 mg, Docusate 250, Lidoderm patches, a urine toxicology screen and an updated medication agreement. Medical dietary adjustments, and continued use of local heat/electrical stimulation. On 01/21/2015 Utilization Review non-certified a request for Post-op physical therapy 2 x 6 to the left shoulder noting the IW had received approval for the surgery as

yet. The MTUS Postsurgical Treatment Guidelines (or ODG) were cited. On 01/21/2015, Utilization Review non-certified a request for associated surgical service: VascoTherm x 30 day rental noting the medical necessity for the vice has not been established. The ACOEM Guidelines, Chapter 9 Shoulder Complaints were cited. On 01/21/2015 Utilization Review non-certified a request for Post-op Norco 10/325mg #60 noting the surgery was not yet authorized. The MTUS Chronic Pain, Opioids were cited. On 01/21/2015, Utilization Review non-certified a request for Post-op Percocet 10/325mg #60 noting the 60 noting the surgery was not yet authorized. The MTUS Chronic Pain, Opioids were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Post-op physical therapy 2 x 6 to the left shoulder:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 26-27.

**Decision rationale:** Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9): Postsurgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks. Postsurgical physical medicine treatment period: 6 months Guidelines recommended 1/2 of the initial 24 visits be performed. In this case, the request is in line with the recommendations. Therefore, determination is for certification. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Associated surgical service: VascoTherm x 30 day rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Continuous flow cryotherapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, there the recommendation exceeds the guidelines recommendation of 7 days. Therefore, the determination is for non-certification.

**Post-op Norco 10/325mg #60:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Postoperative opioids are accepted medication in the preoperative period. Therefore, the determination is for certification. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Post-op Percocet 10/325mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Postoperative opioids are accepted medication in the preoperative period. There is no medical indication why postoperative Percocet should be prescribed in addition to postoperative Norco as both are opioids. The use of drugs with duplicate mechanism of action is not medically necessary. Therefore, determination is for non-certification.