

<b>Case Number:</b>	CM15-0133509		
<b>Date Assigned:</b>	07/28/2015	<b>Date of Injury:</b>	08/01/2011
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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, Indiana, Oregon  
 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 57 year old male who sustained an industrial injury on 08/01/2011 resulting in injury to the left elbow. Treatment provided to date has included: left tennis elbow surgery (2012); bilateral carpal tunnel release (2005); left shoulder replacement surgery (2014); physical therapy; cortisone injections to the neck and left elbow; facet injections to the cervical spine (2012); medications; and conservative therapies/care. Diagnostic tests performed include: MRI of the right shoulder (2015) showing moderate osteoarthritis of the acromioclavicular joint, small fluid in the subacromial subdeltoid bursa, low grade partial intrasubstance tear of the distal superior fibers of the right subscapularis tendon, mild tendinosis of the junction of the supraspinatus and infraspinatus tendons, and increased signal in the posterior superior labrum with multiple paralabral cyst. Other noted dates of injury documented in the medical record include: 05/09/2010, and cumulative trauma injuries from 05/01/2011 through 08/01/2011. There were no noted comorbidities. On 06/08/2015, physician progress report noted complaints of increasing right shoulder pain. There was no pain rating provided, but there was reported grinding of the right with activities. Additional complaints included pain with sleeping. The physical exam revealed glenohumeral tenderness to the right shoulder with minimal acromioclavicular joint tenderness. A Previous progress note (date 05/14/2015) reported decreased range of motion in the right shoulder. The provider noted diagnoses of bilateral glenohumeral joint arthritis of the shoulders, and progressive glenohumeral arthritis of the right shoulder. Plan of care includes right shoulder replacement surgery. The injured worker's work status is full duty. The request for authorization and IMR (independent medical review) includes:

right shoulder replacement surgery, 3 day inpatient hospital stay, pre-operative office visit, 4 post-operative office visits, 12 sessions of physical therapy, 14 day rental of game ready unit, shoulder immobilizer, tramadol/acetaminophen 37.5-325mg #120, naproxen 550mg #120, Zolpidem Tartrate 5mg #30, Zofran 8mg #10, and Colace 100mg #20.

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

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

**Right total shoulder replacement:** 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.

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

**Decision rationale:** CA MTUS/ACOEM is silent on this issue of shoulder replacement. According to the ODG Shoulder section, arthroplasty, "The most common indication for total shoulder arthroplasty is osteoarthritis, but for hemiarthroplasty it is acute fracture. There was a high rate of satisfactory or excellent results after total shoulder arthroplasty for osteoarthritis, but hemiarthroplasty offered less satisfactory results, most likely related to the use of this procedure for trauma." Shoulder arthroplasty is indicated for glenohumeral and acromioclavicular osteoarthritis with severe pain with positive radiographic findings and failure of 6 months of conservative care. In this case the MRI shows only mild to moderate glenohumeral degenerative disease. Therefore the request is not medically necessary.

**Three day inpatient stay:** 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.

**Preoperative appointment:** 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.

**Four post operative appointments: 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 Service: Twelve physical therapy sessions: 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 Service: Game Ready Unit, 14 day rental: 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 Service: Shoulder Immobilizer: 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.

**Tramadol HCL/Acetaminophen 37.5/325mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines tramadol Page(s): 93-94.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence in the records of 6/8/15 of severe pain to warrant Tramadol. Therefore use of Tramadol is not medically necessary.

**Naproxen 550mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 66.

**Decision rationale:** Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 66 states that Naproxen is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. It is used as first line treatment but long-term use is not warranted. In this case the continued use of Naproxen is not warranted, as there is no demonstration of functional improvement from the exam note from 6/8/15 as the pain is increasing. Therefore the request is not medically necessary.

**Zolpidem Tartrate 5mg #30:** 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 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.

**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 non-benzodiazepine 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 6/8/15 of insomnia to warrant Ambien. Therefore the request is not medically necessary.

**Zofran 8mg #10:** Upheld

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

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. In this case the submitted records demonstrate no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore determination is not medically necessary.

**Colace 100mg #20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (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.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of stool softeners. According to the ODG Pain section, opioid induced constipation treatment, if prescribing opioids has been determined to be appropriate, then ODG recommends, under Initiating Therapy, that Prophylactic treatment of constipation should be initiated. In this case there is no documentation of constipation associated with medication. Based on this the request is not medically necessary.