

Case Number:	CM15-0026344		
Date Assigned:	02/18/2015	Date of Injury:	07/01/2014
Decision Date:	03/31/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	02/12/2015

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: Illinois, California, Texas
 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 30-year-old male who sustained an industrial injury on 07/01/14, when he fell from a ladder. Past medical history was negative. The 10/18/14 left shoulder MRI improvement documented a downsloping acromion with mild to moderate acromioclavicular (AC) joint degenerative change and OS acromiale with mild rotator cuff tendinosis and subacromial/subdeltoid bursitis. There was a labral tear with paralabral cyst formation noted. The 1/21/15 treating physician report cited constant grade 8/10 left shoulder pain, increased with attempting to raise his arm overhead. Current medications included Relafen and Norco. Physical exam documented marked loss of shoulder range of motion and pain with range of motion. There was AC joint, biceps tendon and lateral acromial tenderness. Impingement, Speed's, and apprehension signs were positive. There was 4/5 supraspinatus weakness. The diagnosis was left shoulder impingement, bursitis, biceps tendinitis, and AC arthrosis. The treatment plan recommended left shoulder arthroscopy with subacromial decompression and possible SLAP repair, pre-operative studies, and post-operative cold compression therapy, physical therapy x 12 visits, sling, and medications (Percocet, Keflex, Ambien, and Zofran). On 02/09/15, utilization review certified a request for left shoulder arthroscopy with subacromial decompression and possible SLAP repair, and the associated request for pre-operative medical clearance, shoulder sling, 12 sessions of post-op physical therapy, and post-op medications including Percocet, Keflex, and Zofran. The request for pre-operative studies including chest x-ray, EKG and labs (CBC, Chem 7, and PT/PTT/INR) was modified to pre-op studies: EKG and labs (CBC, Chem

7). The requests for ice therapy cold compression therapy for 3 weeks and Ambien 10 mg #30 were non-certified. The Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Services: 1 Pre-operative studies, X-rays, EKG, Labs (CBC, Chem 7, PT/PTT/INR): 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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Coagulation studies are generally reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding or those taking anti-coagulants. The 2/9/15 utilization review certified pre-operative medical clearance and partially certified pre-op studies to include EKG, CBC, and Chem 7. There is no compelling reason based on patient age and apparent negative past medical history to support the medical necessity of additional studies. Therefore, this request is not medically necessary.

Ambien 10mg #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) Mental Illness & Stress

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain (Chronic) Zolpidem (Ambien®)

Decision rationale: The California Medical Treatment Utilization Schedule does not make recommendations relative to zolpidem or insomnia treatment. The Official Disability Guidelines recommend the use of zolpidem as first-line medication for the short term (7-10 day) treatment of insomnia. Guidelines recommend that insomnia treatment be based on the etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Guideline criteria have not been met. There is no current documentation of insomnia. There is no guideline support for the prophylactic prescription of this medication for

post-operative use. The requested quantity of medication exceeds guideline recommendations for no longer than 10 day use. Therefore, this request is not medically necessary.

1 Ice Therapy Cold Compression therapy for 3 weeks: 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) Post-Surgical Physical Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder: Cold compression therapy

Decision rationale: The California MTUS are silent regarding cold compression therapy. The Official Disability Guidelines do not recommend cold compression therapy in for patients undergoing shoulder surgeries. There is no evidence of improved clinical post-operative outcomes for patients using an active cooling and compression device over those using ice bags and appropriately prescribed elastic wrap after upper extremity surgery. There is no compelling reason in the records reviewed to support the medical necessity of a mechanical cold system over standard cold pack in the absence of demonstrated improved clinical efficacy. Therefore, this request is not medically necessary.