

<b>Case Number:</b>	CM14-0197662		
<b>Date Assigned:</b>	12/05/2014	<b>Date of Injury:</b>	10/09/1991
<b>Decision Date:</b>	02/20/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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. 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, Sports Medicine

### 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 male who reported an injury on 10/09/1991. The mechanism of injury was not documented within the clinical records. The injured worker's diagnoses were noted to include shoulder pain. The past treatments included physical therapy and cortisone injections. The ultrasound of the right shoulder, dated 06/03/2014, revealed findings consistent with supraspinatus and infraspinatus tendinosis. The surgical history was noted to include a right shoulder arthroscopy, synovitis, removal of total shoulder arthroplasty bone grafting, and revision hemiarthroplasty. The subjective complaints on 09/26/2014 included right shoulder pain. The objective findings revealed that he has had more than 5 cultures positive for propionibacterium acnes so he has the proverbial royal flush of shoulder surgery. The medications were noted to include OxyContin 10 mg and Percocet 10/325 mg. The treatment plan was to proceed with surgical intervention. A request was received for right shoulder removal of hemiarthroplasty, possible reversed total shoulder arthroplasty, antibiotic spacer placement, total shoulder arthroplasty, Percocet 10/325 mg #60, OxyContin 10 mg #28, physical therapy times 12 visits for the right shoulder, rental of a Vascutherm cold therapy unit, purchase of a shoulder sling, and medical clearance. The Request for Authorization form was dated 10/07/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder removal of hemiarthroplasty- possible reverse total shoulder arthroplasty, antibiotic spacer placement, total shoulder arthroplasty: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Indications for surgery

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

**Decision rationale:** The request for right shoulder removal of hemiarthroplasty possible reverse total shoulder arthroplasty, antibiotic spacer placement, total shoulder arthroplasty is not medically necessary. The Official Disability Guidelines' indications for shoulder arthroplasty are as follows: (1) severe pain preventing good night's sleep or functional disability that interferes with activities of daily living or work; (2) positive radiographic findings (i.e., shoulder joint degeneration, severe joint space stenosis); a (3) tried and failed conservative therapies for at least 6 months to include NSAIDs, intra-articular steroid injections, and physical therapy. There was a lack of documentation in the clinical notes that the injured worker had severe pain with functional disability that was interfering with activities of daily living or work. Additionally, there were no official radiographic findings submitted for review to reveal shoulder joint degeneration or severe joint space stenosis. Furthermore, there was a lack of documentation that the injured worker had tried and failed NSAIDs or physical therapy for at least 6 months prior to requesting surgical intervention. Given the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**Percocet 10/325mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use for a Therapeutic Trial of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

**Decision rationale:** The request for Percocet 10/325 mg #60 is not medically necessary. The California MTUS Chronic Pain Guidelines state 4 domains have been proposed as most relevant for monitoring of chronic pain patients on opioids. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. There was a lack of adequate documentation in the clinical notes submitted of quantified numerical pain relief, side effects, physical and psychosocial functioning, or aberrant behavior. Furthermore, there was no medication frequency provided with the request. Given the information above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**Oxycontin 10mg #28: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain In General Conditions.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

**Decision rationale:** The request for OxyContin 10 mg #28 is not medically necessary. The California MTUS Chronic Pain Guidelines state 4 domains have been proposed as most relevant for monitoring of chronic pain patients on opioids. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. There was a lack of adequate documentation in the clinical notes submitted of quantified numerical pain relief, side effects, physical and psychosocial functioning, or aberrant behavior. Furthermore, the request as submitted did not provide a medication frequency. Given the information above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**Physical Therapy x 12 visits for the right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

**Rental of a vasotherm cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines shoulder procedure summary

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

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

**Purchase of a shoulder sling:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- low back procedure

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Postoperative abduction pillow sling.

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

**Medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines low back procedure summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Preoperative testing, general.

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

**Inpatient stay 1-2 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- hospital length of stay, shoulder procedure summary

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

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