

<b>Case Number:</b>	CM13-0042483		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	03/08/2013
<b>Decision Date:</b>	03/18/2014	<b>UR Denial Date:</b>	10/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas, Michigan, Indiana and Nebraska. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 58-year-old female who reported an injury on 03/08/2013 secondary to repetitive lifting. The patient is diagnosed with impingement syndrome with bicipital tendonitis and labral tear. The patient is currently status post operative arthroscopy, synovectomy, bursectomy, coracoacromial ligament release, Neer type acromioplasty, and modified Mumford procedure on 12/19/2013 by [REDACTED]. The patient was seen by [REDACTED] on 12/12/2013. Physical examination revealed tenderness along the rotator cuff in the biceps tendon and AC joint. It is noted that the patient's MRI indicated longitudinal tear of the biceps tendon with tendonitis. Treatment recommendations included preparation for surgical intervention to include decompression, labrum evaluation, possible biceps tendon release, stabilization, and evaluation of the rotator cuff tear. The patient was provided with a Polar care unit and shoulder immobilizer for postoperative use. The patient was also given prescriptions for Neurontin, Zofran, Flexeril, Naproxen, Tramadol ER, Protonix, Terocin patches, and LidoPro.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-op Medical Clearance H&P:** Upheld

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

**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 Chapter, Preoperative testing, general.

**Decision rationale:** Official Disability Guidelines state preoperative testing including chest radiography, laboratory testing, and echocardiography, is often performed prior to surgical procedures. The decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. The patient does not maintain a past medical history of significant comorbidities. Therefore, preoperative testing is not indicated. As such, the request is non-certified.

**Pre op CMP:** 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).

**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 Chapter, Preoperative testing, general.

**Decision rationale:** Official Disability Guidelines state preoperative testing including chest radiography, laboratory testing, and echocardiography, is often performed prior to surgical procedures. The decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. The patient does not maintain a past medical history of significant comorbidities. Therefore, preoperative testing is not indicated. As such, the request is non-certified.

**Pre op Chest X-ray:** 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).

**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 Chapter, Preoperative testing, general.

**Decision rationale:** The Physician Reviewer's decision rationale: Official Disability Guidelines state preoperative testing including chest radiography, laboratory testing, and echocardiography, is often performed prior to surgical procedures. The decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. The patient does not maintain a past medical history of significant comorbidities. Therefore, preoperative testing is not indicated. As such, the request is non-certified.

**Polar care unit (rental or purchase):** 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).

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

**Decision rationale:** Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after surgery, for up to 10 days including home use. While the patient may meet criteria for a 7 day rental of a continuous flow cryotherapy unit, the current request for a purchase cannot be determined as medically appropriate. Therefore, the request is non-certified

**Post op Amoxicillin:** 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) Infectious Disease Chapter, Amoxicillin (Amoxil®).

**Decision rationale:** Official Disability Guidelines state amoxicillin is recommended as first line treatment for cellulitis and other skin and soft tissue infections. The patient does not meet criteria for the requested medication. As such, the request is non-certified.

**Post op Zofran:** 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), Chronic Pain Chapter, Ondansetron, Antiemetics.

**Decision rationale:** Official Disability Guidelines state ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation, and is also FDA approved for postoperative use. There is no evidence of gastrointestinal complaints. There is no documentation of nausea and vomiting secondary to chemotherapy and/or radiation treatment. The medical necessity for 20 tablets of high dose Zofran 8 mg has not been established. Therefore, the request is non-certified.

**Post op Neurontin:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

**Decision rationale:** California MTUS Guidelines state antiepilepsy drugs are recommended for neuropathic pain. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first line treatment for neuropathic pain. The patient does not maintain a diagnosis of neuropathic pain, diabetic painful neuropathy, or postherpetic neuralgia. There is no evidence of neuropathic pain upon physical examination. The medical necessity for the requested postoperative medication has not been established. Therefore, the request is non-certified.