

<b>Case Number:</b>	CM14-0013177		
<b>Date Assigned:</b>	02/24/2014	<b>Date of Injury:</b>	10/10/1994
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	01/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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. The expert reviewer is Board Certified in Orthopedic surgery and is licensed to practice in California. 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/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 claimant is a 66-year-old female injured in a work related accident on 10/10/94. The clinical records provided for review document that the claimant underwent shoulder surgery in 2003. The report of an MRI dated 11/28/13 identified tendinosis of the biceps tendon, evidence of prior rotator cuff repair of the distal supraspinatus tendon, and no recurrent full thickness findings. There was also evidence of a prior subacromial decompression. A progress report dated 12/30/13 noted continued complaints of pain in the shoulder with objective findings on examination demonstrating well healed portal sites, positive Neer and Hawkins testing, positive impingement testing, positive Speed's and empty can testing. There was tenderness over the paravertebral muscles of the cervical spine with painful cervical range of motion. Given the claimant's ongoing left shoulder complaints, the recommendation was made for revision diagnostic arthroscopy, subacromial decompression, and distal clavicle excision with open mini rotator cuff repair and biceps tenodesis. Records do not indicate recent conservative treatment; however, there is noted prior medication management and physical therapy. There is no indication of recent injection therapy documented. In addition to the surgical recommendation, Levaquin and antibiotics were prescribed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEVAQUIN 750MG #20:** 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) 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); Treatment in Worker's Comp, 18th Edition, 2013 Updates: infectious procedure - Levofloxacin.

**Decision rationale:** California MTUS and ACOEM Guidelines do not address this request. When looking at Official Disability Guidelines, the request for Levaquin in this case is not supported. The need for operative intervention has not been established, thus negating the need for perioperative antibiotic treatment.

**ANTIBIOTICS:** 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); Treatment in Worker's Comp, 18th Edition, 2013 Updates: infectious procedure - Levofloxacin.

**Decision rationale:** California MTUS and ACOEM Guidelines do not address this request. When looking at Official Disability Guidelines criteria, the role of antibiotics in this case is not supported. The need for operative intervention has not been established, thus negating the need for perioperative antibiotic treatment.

**ACROMIOPLASTY RESECTION OF CORACOACROMIAL LIGAMENT AND BURSA AS INDICATED:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**Decision rationale:** Based on California MTUS ACOEM Guidelines, a subacromial decompression and resection of coracoacromial ligament would not be indicated. While this individual is noted to have continued complaints of pain despite a prior left shoulder surgery in 2003, there is currently no indication of recent conservative care including injection therapy provided for his symptoms documented. ACOEM Guidelines in regards to subacromial decompression indicate the need for six months of conservative care including injection therapy prior to proceeding with surgery. The absence of the above documentation would not support the need for operative intervention.

**POSSIBLE DISTAL CLAVICLE RESECTION WITH MINI-OPEN: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. 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); Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure -Partial claviclectomy (Mumford procedure).

**Decision rationale:** California MTUS and ACOEM Guidelines do not address this procedure. When looking at Official Disability Guidelines, a distal clavicle resection would also not be indicated. The need for operative intervention in this case has not been established thus negating the need for this specific portion of the procedure.

**ROTATOR CUFF REPAIR AND BICEPS TENODESIS AS INDICATED: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

**Decision rationale:** California MTUS ACOEM Guidelines would not support a rotator cuff repair or bicipital tenodesis. While this individual has chronic complaints of pain, there is no indication of recurrent rotator cuff pathology on imaging that would support further operative intervention.