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| Case Number: | CM14-0027331 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 10/26/2010 |
| Decision Date: | 10/10/2014 | UR Denial Date: | 02/14/2014 |
| Priority: | Standard | Application Received: | 03/04/2014 |

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 Preventive Medicine 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 patient is a 51-year old female who sustained an industrial injury on 10/26/10. The mechanism of injury was not noted in the records available for review. The patient's most recent complaints during her most recent evaluation by a treating physician on 05/06/14 included persistent pain post-operatively in her shoulders, right worse than left, and in the para-thoracic and peri-scapular musculature. Diagnostic test results (Medical resonance imaging of the cervical spine dated 09/27/10) included degenerative changes at the C5-C6 and C6-C7 levels with moderate bilateral foraminal narrowing at C5-C6 and mild to moderate canal narrowing but no cord compression. There was focal central posterior disc protrusion at C6-C7 which abutted the anterior margin of the cord but no evidence of frank cord compression and no significant foraminal narrowing at C6-C7. Magnetic resonance imaging (MRI) of the right shoulder from 09/27/10 demonstrated a full thickness tear of the of the posterior fibers of the supraspinatus measuring 8x5 mm medial lateral, moderate to severe tendinosis with interstitial tearing, moderate acromioclavicular (AC) arthrosis, broad inferior acromial spur with narrowing of the AC space to 5 mm, mild tendinosis of the intra-articular portion of the long biceps. MRI of the left shoulder dated 10/13/10 showed large interstitial tear of the supraspinatus tendon without evidence of full thickness rotator cuff tear. There was mild tendinopathy at the infraspinatus enthesis. There was a moderate sized subacromial enthesophyte which slightly narrowed the outlet. There was mild inter-articular biceps bursitis. Electrodiagnostic studies dated 10/11/12 showed evidence of left C7 radiculopathy with ongoing denervations; right C8 radiculopathy with ongoing denervations, right carpal tunnel syndrome (CTS), mild suggestive of but not diagnostic per AANEM for right C7 radiculopathy. Repeat MRI scan of the cervical spine dated 12/14/12 showed degenerative disease at C5-C6 superimposed on a congenitally small canal causing mild to moderate canal narrowing and some moderately severe right foraminal

narrowing. There was mild progression of degenerative changes at C5-C6 since prior study of 09/2010. X-rays of the cervical spine dated 04/08/13 showed advanced disc space narrowing at C5-C6 with anterior spurring and retrolisthesis. That retrolisthesis increased with extension. Forward flexion showed reduction of the retrolisthesis. There was facet gapping on extension. Prior treatment included an arthroscopic subacromial decompression and a mini open repair of rotator cuff on 02/17/11. The patient described 45-50% improvement with that surgery. The patient underwent a course of postoperative physical therapy (PT). On 02/05/14, the patient underwent a cervical spine surgery to include C5-C6 and C6-C7 anterior cervical discectomy, fusion and instrumentation. Postoperative x-rays of the cervical spine dated 03/18/2014 showed good alignment of the instrumentation. Medications included gabapentin, tramadol and tizanidine. Per utilization review dated 02/14/14 the request for home health care, postoperative physical therapy, Vicodin and Colace was approved. The request for oral Keflex for postoperative prophylaxis was denied as perioperative antibiotics were given for one day as usual for prophylaxis. During her evaluation by the treating physician on 05/06/14, the patient stated that the incision hurt occasionally but her primary source of pain was in her upper back. The patient had been wearing her cervical collar. The patient stated that she experienced cervical weakness when she removed it. On examination, the patient was tender to palpation along the bilateral trapezii and para-thoracic musculature. The patient was very stiff. There was peri-incisional hyperpigmentation as a result of an allergic reaction to the Mastisol and Steri-strips. She stated that it was diminishing slightly. X-rays of the cervical spine showed good alignment of the instrumentation. The treating physician discussed the strategy for weaning off the brace to help restore cervical musculature strength and requested PT for scapular and thoracic stabilization.

IMR ISSUES, DECISIONS AND RATIONALES

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

KEFLEX 500 MG QTY: 28.00: 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), Infectious Diseases, Cephalexin (Keflex)

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

Decision rationale: Post operative oral antibiotics as prophylaxis are not the standard of care after intraoperative and perioperative antibiotics. No evidence of infection was noted on the patient's most recent physical examination. Cephalexin is not medically necessary due to the lack of evidence for an infection as well as the antibiotics already used for the procedure.