

Case Number:	CM14-0040698		
Date Assigned:	06/27/2014	Date of Injury:	10/21/2013
Decision Date:	08/05/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/07/2014

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 Orthopaedic 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:

This 62-year-old male sustained an industrial injury on 10/21/13. Injury occurred when he tripped over a brick in a yard leaving a patient's home. He landed on the right side of his body with complaints of right knee, hip, and shoulder pain. Conservative treatment included physical therapy, home exercise, activity modification, and anti-inflammatories. The 1/24/14 right shoulder magnetic resonance imaging (MRI) impression documented rotator cuff tendinopathy with focal full-thickness tear at the supraspinatus tendon insertion, subacromial/subdeltoid bursitis, and marked osteoarthritis of the acromioclavicular joint with osteophytic improvement of the subacromial space. The 3/17/14 right shoulder x-ray impression documented prominent degenerative changes of the acromioclavicular joint, likely causing impingement upon the rotator cuff. The 3/18/14 orthopedic report documented physical exam findings of right shoulder forward elevation to 90 degrees, external rotation to 10 degrees, and internal rotation to the buttock level. The acromioclavicular joint, greater tuberosity and proximal biceps were tender. There was 3/5 rotator cuff strength in the infraspinatus, supraspinatus, and subscapularis, all with positive tendon signs. Impingement test was positive. There was a full thickness rotator cuff tear and impingement with symptomatic acromioclavicular joint arthritis. A request for right shoulder decompression and debridement, distal clavicle excision and treatment of rotator cuff or labral pathology was recommended. There was a possibility of adhesive capsulitis. The 3/26/14 utilization review denied the requests for right shoulder surgery and associated medications, as the medical necessity was not established relative to significant deficits and failed conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder possible labral repair, possible rotator cuff repair, subacromial decompression, distal clavicle excision, debridement: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for SLAP lesions, Surgery for impingement syndrome, Partial Claviclectomy.

Decision rationale: The California MTUS guidelines provide general recommendations for rotator cuff repair and impingement syndrome. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. The preferred procedure is arthroscopic decompression. The Official Disability Guidelines for rotator cuff repair with a diagnosis of full thickness tear typically require clinical findings of shoulder pain and inability to elevate the arm, weakness with abduction testing, atrophy of shoulder musculature, and positive imaging evidence of rotator cuff deficit. Criteria for acromioplasty generally require 3 to 6 months of conservative treatment directed toward gaining full range of motion. Criteria include subjective, objective, and imaging clinical exam findings with positive evidence for impingement including positive diagnostic injection test. Guideline criteria have been met. This patient presents with imaging findings of rotator cuff tear and impingement. There is persistent function limiting pain with clinical exam findings of impingement. Adhesive capsulitis has been opined as a possibility. Conservative treatment, including physical therapy, activity modification, home exercise, and anti-inflammatory medication, has been tried and has failed. Therefore, this request for right shoulder possible labral repair, possible rotator cuff repair, subacromial decompression, distal clavicle excision, and debridement is medically necessary.

Keflex 500mg #12: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Bratzler DW, et al. Clinical practice guidelines for antimicrobial prophylaxis in surgery. Am J Health Syst Pharm. 2013 Feb 1;70(3):195-283.

Decision rationale: The California MTUS and the Official Disability Guidelines do not provide guidance for post-operative antibiotics. The National Guideline Clearinghouse was searched. Clinical practice guidelines state that antimicrobial prophylaxis is not recommended for patients undergoing clean orthopedic procedures, including knee, hand, and foot procedures; arthroscopy; and other procedures without instrumentation or implantation of foreign materials. Guideline criteria have been met. An arthroscopic procedure is planned which overall does meet guideline

recommendations for prophylactic antibiotic use. Therefore, this request for Keflex 500mg #12 is medically necessary.

Zofran 4mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice guidelines for postanesthetic care: an updated report by the American Society of Anesthesiologists Task Force on Postanesthetic Care. *Anesthesiology*. 2013 Feb;118(2):291-307.

Decision rationale: The California MTUS and the Official Disability Guidelines do not provide recommendations for anti-emetics for post-operative use. The National Guideline Clearinghouse was searched. Practice guidelines for post-anesthetic care support the use of anti-emetics, such as Zofran, for patients when indicated. The routine use of pharmacologic prophylaxis of nausea and vomiting is not recommended. There are no specific indications for the prescription of anti-emetics for this patient. The specific prescription information, including quantity and duration of use is also not provided. Therefore, this request for Zofran 4mg is not medically necessary.