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| Case Number: | CM14-0091793 | | |
| Date Assigned: | 07/25/2014 | Date of Injury: | 04/08/2013 |
| Decision Date: | 08/28/2014 | UR Denial Date: | 05/23/2014 |
| Priority: | Standard | Application Received: | 06/17/2014 |

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:

This 58-year-old male energy technician sustained an industrial injury on 4/8/13. The injury occurred when he pushed a ladder overhead onto the top of his truck, and felt a pop and pain in the right shoulder. Past surgical history was positive for right shoulder arthroscopic rotator cuff repair and subacromial decompression on 7/24/00. The right shoulder MRI impression on 10/21/13 documented post-surgical changes with thinning of the anterior supraspinatus tendon at the footprint which could represent partial thickness tearing. There was a probable infraspinatus tear. There was a moderate amount of fluid in the subacromial/subdeltoid bursa region. There was moderate glenohumeral osteoarthritis with scattered regions of high-grade chondrosis and abnormal glenoid labrum morphology suggestive of a tear. There was partial thickness tearing and tendinosis of the intra-articular portion of the long head of the biceps tendon. The 1/20/14 and 3/27/14 progress reports cited right shoulder pain with considerable difficulty in activities of daily living. Physical exam findings documented anterolateral subacromial tenderness to palpation, marked weakness with resisted internal/external rotation, and positive Neer and Hawkin's impingement signs. Range of motion testing documented flexion 90, abduction, and external rotation 45 degrees, with internal rotation to L5. The patient was diagnosed with impingement syndrome and surgery was recommended. The patient underwent right shoulder arthroscopic subacromial decompression and biceps tenotomy on 4/16/14. The 5/23/14 utilization review denied the retrospective request for right shoulder arthroscopic subacromial decompression and biceps tenotomy and associated post-op requests as there were no imaging findings and conservative treatment had not been completed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Right Shoulder Arthroscopic Subacromial Decompression (DOS: 04/16/14):
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Edition, Indications for Surgery.

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 impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines for acromioplasty generally require conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. This patient presented with significant symptoms and considerable loss of functional ability. Records document marked loss of range of motion, positive impingement testing, abduction and external rotation weakness, and positive imaging findings consistent with impingement. Reasonable non-operative treatment appears to have been tried and failed. Therefore, this retrospective request for right shoulder arthroscopic subacromial decompression was medically necessary.

Retrospective: Biceps Tenotomy: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Edition, Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for ruptured biceps tendon.

Decision rationale: The California Medical Treatment Utilization Schedule indicates that biceps tendon injuries can generally be managed conservatively because there is no accompanying functional disability. The Official Disability Guidelines for biceps tenotomy state that nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendon. There was imaging evidence of biceps tearing. Significant symptoms and considerable difficulty in activities of daily living are noted. Reasonable non-operative treatment appears to have been tried and failed. Therefore, this retrospective surgical request including biceps tenotomy was medically necessary.

Percocet 5/325 mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids, specific drug list Page(s): 76-80, 92.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support the use of Oxycodone/Acetaminophen (Percocet) for moderate to moderately severe pain on an as needed basis. Short-acting opioids also known as normal-release or immediate-release opioids are seen as an effective method in controlling both acute and chronic pain. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guideline criteria have been met for the post-operative use of Percocet. Records indicate that the patient has been using Percocet in the management of his right shoulder pain since 11/19/13 after failure of Norco. Given the elevated pain needs in the immediate postoperative period, this request is reasonable. Therefore, this request for Percocet 5/325 mg #120 is medically necessary.

Prophylactic Antibiotic: 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 Other Medical Treatment Guideline or Medical Evidence: 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 Official Disability Guidelines do not address the use of prophylactic antibiotics in the perioperative or post-operative course. Clinical practice guidelines state that antimicrobial prophylaxis is generally not recommended for patients undergoing clean orthopedic procedures, arthroscopy, and other procedures without instrumentation or implantation of foreign materials. This non-specific request provides insufficient information to establish medical necessity. Therefore, this request for a prophylactic antibiotic is not medically necessary.

DVT Prophylaxis with Pneumatic Compression Devices: 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).

Decision rationale: The California MTUS guidelines are silent with regard to DVT prophylaxis and pneumatic compression devices. The Official Disability Guidelines recommend identifying subjects who are at a high risk of developing venous thrombosis and providing DVT prophylactic measures, such as consideration for anticoagulation therapy. The administration of DVT prophylaxis is not generally recommended in shoulder arthroscopic procedures. Guideline criteria have not been met. There were no significantly increased DVT risk factors identified for this \

patient, relative to the 4/16/14 right shoulder arthroscopy. There is no documentation that anticoagulation therapy was contraindicated, or standard compression stockings insufficient, to warrant the use of mechanical prophylaxis. Therefore, this request for DVT prophylaxis with pneumatic compression devices is not medically necessary.