

<b>Case Number:</b>	CM14-0208743		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	06/27/2013
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California  
Certification(s)/Specialty: Emergency Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient with reported date of injury on 6/27/2013. No mechanism of injury was documented in the provided documents. Patient has a diagnosis of cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, L shoulder sprain/strain, lumbar radiculopathy, lumbar facet syndrome, L shoulder degerative changes, acromioclavicular joint disorder, acromiohumeral narrowing and impingement syndrome. Medical reports reviewed. Last report available until 11/5/14. Utilization review shows that requested L shoulder surgery (L shoulder arthroscopic surgery, distal clavicle resection/Mumford procedure, partial acromioplasty and resection of corocoacromial ligament debridement and possible rotator cuff repair) was approved. UR also approved shoulder brace, physical therapy, shoulder block, cooling unit, home exercise kit, partial certification of medical clearance and Tramadol. Records concerning pain complaints and exam were reviewed. Imaging reports were reviewed. Patient is in fifties and has noted controlled diabetes as only listed medical problems. A note mentions treatment for asthma/bronchitis from the 1990s but nothing more recent. There is no appropriate documentation of medical problems listed. No appropriate medication list was documented. Only medications listed include topical cream and lidoderm patch. Patient is noted to be on oral medications for diabetes but nothing else is documented on record. Independent Medical Review is for Pre-operative clearance with internist including labs(CBC, PT, PTT, Chem12, A1c and UA/PFT/EKG/CXR); Post-operative acupuncture of L shoulder; DVT compression pump and stockings(rental or purchase); CPM machine(rental or purchase); IFC unit and supplied(Rental or purchase); Transportation to surgery center; Keflex 500mg #20 and Norco 5/325mg #60. Prior Utilization Review on 12/12/14 recommended

modifications or denial of services under review. It modified post-operative acupuncture to 6 sessions.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Pre-operative medical clearance with an internist/labs to include CBC, PT, PTT, CHEM12, A1c, and UA/PFT/EKG/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:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92, Chronic Pain Treatment Guidelines Introduction Page(s): 1. Decision based on Non-MTUS Citation Low back

**Decision rationale:** As per ACOEM and MTUS guidelines, referrals may be appropriate if the caretaker is not able to manage patient's illness and function beyond their capability. Patient only has diabetes as a comorbidity and poor documentation of other potential operative complications. Pre-operative evaluation/clearance by internal medicine is medically necessary. However the requested labs and testing are not medically necessary. MTUS Chronic pain and ACOEM Guidelines do have any sections that relate to laboratory testing as a topic. As per Official Disability Guidelines recommends preoperative testing pertaining to certain criteria and only with medical justification. Some of the requested laboratory testing is appropriate. This patient only has diabetes and has been approved for what appears to be a regional block and not general anesthesia. However, multiple other requested testing is not appropriate. There is no justification as to why EKG, Chest X-rays, pulmonary function testing was requested. Preoperative testing as requested is not medically necessary. Since the requested lab and other ancillary testing is not medically necessary, this entire request is considered not medically necessary.

**Post-operative acupuncture sessions for the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** As per MTUS Acupuncture Guidelines, acupuncture may be recommended in combination with surgical intervention and rehabilitation to hasten recovery. It only recommends 3-6 sessions to determine initial response. This request is for either 12 or an unlisted number of sessions. This request for acupuncture does not meet criteria and is not medically necessary.

**DVT compression pump & stockings (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), Shoulder and Knee & Leg Chapters

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and Leg

**Decision rationale:** MTUS Chronic pain or ACOEM Guidelines do not have any adequate information concerning this topic. Official Disability Guidelines (ODG) states that patient at high risk of venous thrombosis should be identified and prophylactic measures should be considered. Primary recommendation includes use of anticoagulants or aspirin. Mechanical compression and compression garments may be beneficial. ODG recommends up to 7-10 days of postsurgical prophylaxis is ideal and may be extended up to 28 days in high risk patients. The provider has failed to provide any concurrent risk factors for DVT such as current medical problems or functional status or plan for physical therapy. There is no provided evidence that patient is high risk for DVT. Provider has not documented why oral medications which are first line treatment is not considered and why compression device is needed instead. DVT compression pump is not medically necessary.

**CPM Machine/kit (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), Shoulder Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder

**Decision rationale:** MTUS Chronic pain and ACOEM Guidelines do not have any sections that relate to this topic. As per Official Disability Guidelines, continuous passive motion (CPM) is recommended for adhesive capsulitis but not for shoulder rotator cuff problems. Patient has been approved for surgery and review of guidelines does not recommend post-operative use. It is unclear why this was requested. Continuous Passive Motion of shoulder is not medically necessary.

**IFC unit & supplies (rental or purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** As per MTUS Chronic pain guidelines, Interferential Current Stimulation is not recommended as isolated modality. There is very little evidence to show it is superior to standard Transcutaneous Electrical Nerve Stimulation (TENS). The documentation does not

meet guideline criteria for recommendation. There is no documentation of failure of standard therapy or poor pain control on medication. It is unclear why ICS was requested. ICS is not medically necessary.

**Transportation to surgery center:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Special Policy Bulletins Number: 0218

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [http://www.dhcs.ca.gov/services/medical/Documents/ManCriteria\\_32\\_MedTrans.htm](http://www.dhcs.ca.gov/services/medical/Documents/ManCriteria_32_MedTrans.htm)

**Decision rationale:** MTUS Chronic pain and ACOEM Guidelines do have any sections that relate to this topic. As per California Department of Health Care Services manual, patient does not meet any criteria for nonemergency medical transportation. Patient does not have any medical condition that would prohibit the use of private or public transportation. The documentation provided does not support medical need for transportation.

**Keflex 500 mg, twenty count:** 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 Bratzler DW, Dellinger EP, Olsen KM, Perl TM, Auwaerter PG, Bolon MK, Fish DN, Napolitano LM, Sawyer RG, Slain D, Steinberg JP, Weinstein RA. Clinical practice guidelines for antimicrobial prophylaxis in surgery. Am J Health Syst Pharm. 2013 Feb 1;70(3):195-283.

**Decision rationale:** There are no sections in the MTUS Chronic pain, ACOEM or Official Disability Guidelines concerning this issue. Antibiotics may be given for postoperative prophylaxis for infections. Provider prescribed the medication for post-operative prophylaxis. As per clinical practice guideline as quoted above, prophylactic antibiotics are usually only recommended as single dose or less than 24hours. The number of tablets prescribed is not appropriate. Keflex is not medical necessary.

**Norco 5/325 mg, sixty count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Trial of Opioids Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

**Decision rationale:** Hydrocodone/acetaminophen is Norco and contains an opioid. As per MTUS chronic pain guidelines, initiation of opioids require establishment of a treatment plan, current pain/pain relief assessment and failure of non-opioid treatment. Provider has failed to document all components to recommend initialization of an opioid. The prescription is for post-operative pain control however, the number of tablets is excessive for the immediate post-operative pain period. There is no documentation of pain or long term plan. Patient was also prescribed and approved for Tramadol. It is no safe or appropriate for initialization of 2 opioids at the same time due to risk of side effects and overdose. Norco is not medically necessary.