

<b>Case Number:</b>	CM15-0180930		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	05/08/2009
<b>Decision Date:</b>	12/04/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 59-year-old female, who sustained an industrial-work injury on 5-8-09. She reported initial complaints of right upper extremity pain. The injured worker was diagnosed as having impingement syndrome, right epicondylitis, carpal tunnel syndrome, and chronic pain. Treatment to date has included medication, injections (several) to shoulder and elbow, braces, transcutaneous electrical nerve stimulation (TENS) unit, injections to the carpal tunnel with benefit, and physical therapy (12 sessions) with pain relief. MRI results were reported on 11-22-12 of the right shoulder revealed type 2 acromion with mild downsloping with degenerative changes of the AC (acromioclavicular) joint, articular sided partial thickness tear at the insertion of the infraspinatus on the posterior shelf of greater tuberosity measuring 12 x 12mm with 50% of the tendon thickness, and moderate osteoarthritis of the glenohumeral joint with significant cartilage loss and contour deformity of the humerus head and glenoid rim. Currently, the injured worker complains of pain to shoulder, right wrist and hand along with numbness and tingling in the thumb and first and long finger. There was difficulty with fine motor skills and sleep was affected. Per the QME (qualified medical exam) on 8-11-15, exam noted restricted right shoulder range of motion, 4+ to 5-out of 5 muscle strength, tenderness over the rotator cuff, biceps tendon, acromioclavicular joint and posterior capsule of the right shoulder, positive impingement test, Hawkin's test, and Speed's test on the right shoulder, tenderness over the carpal tunnel and medial and lateral epicondyle to the right side, positive Tinel's, reverse Phalen's on the right carpal tunnel are noted. Current plan of care includes surgery, medication, and testing. The Request for Authorization requested service to include Pre-op CMP (complete metabolic panel),

Associated surgical service: Shoulder immobilizer, Associated surgical service: Polar care 21-day rental, Amoxicillin-Clavulanate (Augmentin) 675/125mg, #40, Gabapentin (Neurontin) 600mg, #180, and Ondansetron (Zofran) 8mg, #20. The Utilization Review on 9-3-15 partially certified the request for Pre-op CMP (complete metabolic panel), Associated surgical service: Shoulder immobilizer, Associated surgical service: Polar care 21-day rental and denied Amoxicillin-Clavulanate (Augmentin) 675/125mg, #40, Gabapentin (Neurontin) 600mg, #180, and Ondansetron (Zofran) 8mg, #20, per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Medical Treatment Guidelines 2009 and Official Disability Guidelines.

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

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

#### **Pre-op CMP: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The CA MTUS/ACOEM Guidelines are silent on the issue of preoperative clearance and testing. According to the Official Disability Guidelines, preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. The Official disability Guidelines states, that these investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is healthy without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore, the request is not medically necessary.

#### **Associated surgical service: Shoulder immobilizer: 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 (Acute and Chronic) Chapter.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

**Decision rationale:** The California MTUS Guidelines, recommends a brief use of the sling for severe shoulder pain (1-2 days) with pendulum exercises to prevent stiffness and cases of rotator cuff conditions, and prolonged use of the sling only for symptom control is not

supported. In this case, the request is for shoulder immobilizer, which restricts motion to a far more significant degree than a simple post-operative sling. The prolonged immobilization places the worker at risk for adhesive capsulitis. Therefore, the request is not medically necessary.

**Associated surgical service: Polar care (21-day rental): 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 (Acute and Chronic) Chapter.

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

**Decision rationale:** The CA MTUS/ACOEM Guidelines are silent on the issue of shoulder cryotherapy. According to the Official Disability Guidelines, continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case, the requested duration exceeds the guideline recommendations and the request is therefore not medically necessary.

**Amoxicillin-Clavulanate (Augmentin) 675/125mg, #40: 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 disease.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Family Physician Journal, 2002 July 1; 66 (1): 119-125, Common bacterial skin infections, Stulberg DL, Penrod MA, Blatny RA.

**Decision rationale:** The CA MTUS/ACOEM and ODG are silent on the issue of antibiotic use. An alternative guideline was utilized. According to the American Family Physician Journal, antibiotics are used to treat skin infections and minor wound infections. It was found from a review of the medical record submitted of no evidence of a wound infection to warrant antibiotic prophylaxis. The request the antibiotic is therefore not medically necessary and appropriate.

**Gabapentin (Neurontin) 600mg, #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** According to the CA MTUS Chronic Pain Treatment Guidelines, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note does not demonstrate evidence

neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore, the request is not medically necessary.

**Ondansetron (Zofran) 8mg, #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), Pain Chapter.

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

**Decision rationale:** The CA MTUS/ACOEM Guidelines are silent on the issue of Zofran for postoperative use. According to the Official Disability Guidelines, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. In this case, the submitted records demonstrate no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore, the request is not medically necessary.