MAXIMUS Federal Services

Case Number:	CM14-0173438		
Date Assigned:	10/24/2014	Date of Injury:	12/13/2010
Decision Date:	12/03/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	10/21/2014

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 Surgeon and is licensed to practice in Maine, Nebraska and Texas. 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 injured worker is a 56-year-old male who reported an injury on 12/13/2010. The mechanism of injury involved a fall. The current diagnoses include right shoulder rotator cuff tear, right shoulder AC arthrosis, left knee meniscus tear, and left knee degenerative joint disease. The injured worker was evaluated on 06/13/2014 with complaints of 7/10 right shoulder pain and 8/10 left knee pain. Previous conservative treatment is noted to include medications, chiropractic therapy, lumbar epidural steroid injection, lumbar medial branch block, acupuncture, and physical therapy. The current medication regimen includes Flexeril, Norco, and Docuprene. Physical examination of the right shoulder revealed 120 degree flexion, 60 degree extension, 100 degree abduction, 45 degree external rotation, 70 degree internal rotation, tenderness to palpation over the AC joint and lateral acromion, bicep tendon tenderness, pain with range of motion, positive Neer and Hawkins sign, positive O'Brien's sign, and normal motor strength. Treatment recommendations at that time included a right shoulder arthroscopy with rotator cuff repair, subacromial decompression and distal clavicle resection. Postoperative medication was also requested on that date. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associate Surgical Service: Keflex 500mg #12: 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)-TWC, Infectious Diseases Procedure Summary

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

Decision rationale: The Official Disability Guidelines recommend Keflex as a first line treatment for cellulitis and other skin and soft tissue infections. The injured worker does not maintain a diagnosis of cellulitis. The injured worker has been issued authorization for a right shoulder arthroscopy; however, the use of Keflex is not supported as a standard of care. There is also no frequency listed in the request. As such, the request is not medically necessary.

Associate Surgical Service: Ambien, #30: 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)-TWC, Zolpidem (Ambien)

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

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset. There is no indication that the injured worker suffers from insomnia or a sleep disorder. There is also no documentation of a failure to respond to non-pharmacologic treatment for insomnia prior to the request for a prescription product. There is no strength or frequency listed in the request. Therefore, the request is not medically appropriate.

Associate Surgical Service: Zofran, #30: 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)-TWC, Anti-emetics (for opioid nausea)

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

Decision rationale: The Official Disability Guidelines do not recommend Ondansetron as a treatment for nausea and vomiting secondary to chronic opioid use. It has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. Therefore, the injured worker does not meet criteria for the requested medication. There is also no strength or frequency listed in the request. As such, the request is not medically necessary.

Associate Surgical Service: Pre-Operative clearance with MD: 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)-TWC Low Back Procedure Summary

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, Preoperative Testing, General

Decision rationale: The Official Disability Guidelines state preoperative testing is guided by the injured workers clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or any comorbidity that would warrant the need for preoperative medical clearance. As such, the request is not medically appropriate.

Associate Surgical Service: Ice Therapy times six (6) weeks,: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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, Continuous Flow Cryotherapy

Decision rationale: The Official Disability Guidelines state continuous flow cryotherapy is recommended following surgery for up to 7 days. The injured worker has been issued authorization for a right shoulder arthroscopy. However, the request for ice therapy for 6 weeks greatly exceeds guideline recommendations. Therefore, the request is not medically appropriate.