

Case Number:	CM13-0038792		
Date Assigned:	12/18/2013	Date of Injury:	10/12/2011
Decision Date:	02/19/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Cardiology and is licensed to practice in 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 physician 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 patient is a 38-year-old male who reported an injury on 10/12/2011, due to carrying a ladder that struck his left shoulder after he fell into a hole. The patient was conservatively treated with physical therapy, medications, a TENS unit, and corticosteroid injections. The patient had persistent left shoulder pain and surgical intervention was recommended. The patient underwent left shoulder arthroscopy, synovectomy, bursectomy, coracoacromial ligament release, acromioplasty, and a modified Mumford procedure with labral repair on 09/23/2013. The patient's most recent clinical exam findings included shoulder abduction at 190 degrees with discomfort and weakness to resistance. It was also noted that the patient was very sensitive to light touch around the incision; however, the incision had a well-healed appearance. The patient had tenderness to palpation along the trapezius musculature. The patient's diagnoses included discogenic cervical conditions with radicular component, impingement syndrome of the left shoulder, and depression. The patient's treatment plan included continuation of medications and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Amoxicillin Clavulanate 875mg #20 between 9/10/2013 and 11/18/2013:

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), Infectious Disease Chapter, Skin & soft tissue infections

Decision rationale: The retrospective request for amoxicillin clavulanate 875 mg #20 between 09/10/2013 and 11/18/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient underwent surgical intervention. Official Disability Guidelines recommend this medication as a first-line treatment for soft tissue infection. The clinical documentation submitted for review does not provide any evidence that the patient has any type of infection. There were no laboratory results submitted for review to support that the patient has any type of infection. As such, the retrospective request for amoxicillin clavulanate 875 mg #20 between 09/10/2013 and 11/18/2013 is not medically necessary or appropriate.

Retrospective Norco 10/325mg #120 between 9/10/2013 and 11/18/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen (Norco).

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

Decision rationale: The retrospective request for Norco 10/325mg #120 between 09/10/2013 and 11/18/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that this medication was requested for moderate to severe pain related to a scheduled surgical intervention. However, the clinical documentation submitted for review also provides evidence that the patient has already been prescribed Vicodin 5/500 mg for moderate to severe pain. California Medical Treatment Utilization Schedule does recommend opioids for moderate to severe pain at the lowest dose for the shortest amount of time. The requested Norco 10/325 mg exceeds minimum dosing recommendations. Additionally, as the patient is already prescribed an opioid for pain control, the need for additional medication is not clearly indicated within the documentation. As such, the requested Norco 10/325 mg #120 between 09/10/2013 and 11/18/2013 is not medically necessary or appropriate.

Retrospective Zofran 8mg #20 for DOS 9/10/2013: 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), Pain Chapter, Anti-emetics

Decision rationale: The retrospective request for Zofran 8 mg #20 for date of service 09/10/2013 is not medically necessary or appropriate. The clinical documentation submitted for

review does provide evidence that the patient was scheduled for surgical intervention. Official Disability Guidelines do recommend the usage of Zofran in the management of postsurgical nausea and vomiting. However, need for this medication could not be determined pre-surgically. Official Disability Guidelines also recommend the use of Zofran for cancer-related treatments and acute exacerbations of gastritis. The clinical documentation does not provide any evidence that the patient is receiving cancer treatments or is experiencing acute gastritis. Therefore, the retrospective review for Zofran 8 mg 20 for date of service 09/10/2013 is not medically necessary or appropriate.

Retrospective Amoxicillin Clavulanate 875mg #20 for DOS 9/10/2013: 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), Infectious Disease Chapter, Skin & soft tissue infections

Decision rationale: The retrospective request for amoxicillin clavulanate 875 mg #20 for date of service 09/10/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient underwent surgical intervention. Official Disability Guidelines recommend this medication as a first-line treatment for soft tissue infection. The clinical documentation submitted for review does not provide any evidence that the patient has any type of infection. There were no laboratory results submitted for review to support that the patient has any type of infection. As such, the retrospective request for amoxicillin clavulanate 875 mg #20 for date of service 09/10/2013 is not medically necessary or appropriate.

Retrospective Gabapentin 600mg #90 for DOS 9/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-18.

Decision rationale: The retrospective request for gabapentin 600 mg #90 for date of service 09/10/2013 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of antiepileptic drugs as an option for postoperative pain. Although the patient was scheduled to undergo an operative procedure on the date of service, the procedure had not yet occurred. Therefore, postsurgical medications would not be supported. As such, the retrospective request for gabapentin 600 mg #90 for date of service 09/10/2013 is not medically necessary or appropriate.