

Case Number:	CM14-0004177		
Date Assigned:	02/05/2014	Date of Injury:	01/20/2011
Decision Date:	06/24/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/10/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 42-year-old female with date of injury 01/20/2011. Per treating physicians report 11/20/2013, the patient presents with chronic shoulder and low back pain with listed diagnoses of: 1. Impingement syndrome of the left shoulder, biceps tendinitis rotator cuff, and AC joint inflammation. 2. Lumbar discogenic condition with radicular component down left lower extremity. 3. Discogenic cervical condition with radicular component down his upper extremity. Under treatment plan authorization, prospective request was for Remeron, gabapentin, for neuropathic pain, Protonix for upset stomach, tramadol ER for pain, LidoPro lotion, Flexeril. For left shoulder, arthroscopic decompression Mumford procedure and evaluation of labrum is recommended. For postoperative care, ReJuveness, pain catheter, medication including amoxicillin for 10 days for postoperative infection, Zofran #20, and Norco #120 for postoperative pain. The patient had an MRI of the shoulder 02/14/2012 which showed no full-thickness tear of the rotator cuff, supraspinatus tendinopathy, small amount of fluid in the bursa, AC joint arthropathy. Treating physician's report 12/18/2013 states that the patient has left shoulder pain, back pain a 9/10, has been out of medication to manage pain for a while, difficult to function during the day. Again, shoulder arthroscopic surgery was recommended, including postoperative measures. A list of medications was recommended for patient's continued pain. Utilization review letter is dated 12/18/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZOFRAN 8MG #20: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACUPUNCTURE MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines have the following regarding Zofran (Ondansetron): Not recommended for nausea and vomiting secondary to chronic opioid use. See Antiemetics (for opioid nausea).

Decision rationale: This patient presents with chronic shoulder and low back pain. The current request is for Zofran #120 for postoperative nausea. Review of the reports does not show whether or not the patient is authorized or has had shoulder surgery. MRI of the shoulder from 02/14/2012 did not show rotator cuff tear but tendinopathy and bursitis findings. When reading ODG Guidelines regarding Zofran, it is indicated for postoperative nausea and vomiting. The request as stated, should surgery take place for shoulder, is appropriate and consistent with ODG Guidelines.

NEURONTIN 600MG #180: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Gabapentin (Neurontin®, Gabarone®, generic available).

Decision rationale: This patient presents with chronic shoulder and low back pain. The request is for Neurontin 600 mg #180 which appears to have been denied by utilization review assuming that this was prescribed for postoperative pain management. However, review of the reports show that this patient suffers from chronic pain of the shoulder and low back, and Neurontin is prescribed to manage patient's chronic radicular symptoms particularly the pain that radiate down to lower extremities. Review of the reports show that the patient does have significant moderately severe pain in intensity of 9/10 particularly since the medications have been denied. The patient had an MRI of the lumbar spine from 01/07/2013 that showed left foraminal disk bulge at L2-L4 with narrowing, 4-mm posterior disk bulge at L4-L5 with subtle irregularity of the L5 nerve and 3-mm disk bulge noted at L5-S1 with left-sided foraminal stenosis. MTUS Guidelines do support gabapentin for neuropathic type of pain as well as possibly for other chronic pain conditions. Review of the progress reports indicate that without these medications, his pain level has been quite high up to 9/10, compromising her ability to function. Given the patient's diagnosis of radicular symptoms, MRI findings, and persistent chronic severe pain, the request is medically necessary.

RUJVENESS 1 SILICONE SHEETING TO REDUCE SCARRING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POST SURGICAL TREATMENT GUIDELINES, ,

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: http://www.aetna.com/cpb/medical/data/300_399/0389.html Clinical Policy Bulletin: Hypertrophic Scars and Keloids Number: 0389 Policy Aetna considers silicone products (e.g., sheeting, gels, rigid shells) experimental and investigational for the treatment of hypertrophic scars or keloids because there is inadequate evidence from prospective randomized clinical trials in the peer-reviewed

Decision rationale: This patient presents with chronic shoulder and low back pain. The treating physician has asked for postoperative use of ReJuveness, a silicone sheeting to reduce scarring, following arthroscopic surgery of the shoulder. There is lack of medical evidence that silicone sheeting can reduce scarring. Furthermore, the proposed surgery is arthroscopic surgery which hardly leaves much scar. The treating physician does not explain how silicone sheeting can reduce scarring and why this patient is anticipated to develop any significant scarring that would benefit from silicone. MTUS, ACOEM and ODG do not discuss this issue but AETNA considers silicone experimental lacking clinical evidence for treatment of hypertrophic scar. The treating physician appears to be recommending ReJuveness on a routine basis without any specific discussion regarding this patient's particular potential for over scarring. Furthermore, there is lack of medical evidence that silicone sheeting can help reduce scarring. The request is not medically necessary.

AMOXICILLIN & CLAVUANATE 875MG #20: Overturned

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) ODG guideline under infectious Diseases under Amoxicillin Recommended as first-line treatment for cellulitis and other conditions.

Decision rationale: This patient presents with chronic shoulder and low back pain. The request is for amoxicillin for postoperative use. The treating physician has recommended left shoulder arthroscopic surgery. This request was denied by utilization review letter 12/18/2013 with a rationale that surgery had not been authorized yet. Review of the reports does not show evidence that the surgery has been authorized nor that it has taken place. MRI of the shoulder shows minimal findings with no rotator cuff tear and with tendinopathy only as well as bursitis. However, the request was for postoperative antibiotic use. If the surgery should take place postoperative short course of antibiotics can be and often utilized to prevent postoperative infection. There is conflicting evidence regarding postoperative use of antibiotics following arthroscopic surgery. However, at this point, it should be left open as a treating physician's option, depending on preoperative evaluation and risk assessment for postoperative care.

Furthermore, length of surgery, and type of intervention and postoperative recovery would determine whether or not antibiotic use would be appropriate. Therefore, amoxicillin for postoperative use at the discretion of the surgeon is medically necessary.