

Case Number:	CM14-0017445		
Date Assigned:	04/14/2014	Date of Injury:	06/12/1998
Decision Date:	05/30/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/11/2014

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 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:

The injured worker is a 48-year-old female who reported an injury on 06/12/1998 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her left shoulder, left upper extremity, cervical spine, and experienced emotional distress. The injured worker's treatment history included left shoulder surgery, an intrathecal pain pump, cervical epidural steroid injections, psychological support, and multiple medications. The injured worker was evaluated on 11/21/2013. It was documented that she used an electric wheelchair for ambulation, lacked dentation, and was at the appointment for a pain pump refill. Physical findings included bilateral upper extremity weakness and a positive axial head compression test. The injured worker's diagnoses included severe chronic pain, upper extremity complex regional pain syndrome with residual weakness, opioid tolerance, left sacroiliitis with gait disturbance and right cervical radiculitis. The injured worker's treatment plan included a refill of the injured worker's pain pump, authorization for Xanax, and a neurosurgical consultation. A request was made for ciprofloxacin.

IMR ISSUES, DECISIONS AND RATIONALES

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

CIPROFLOXACIN 500MG, QTY 10 DAY SUPPLY 5: 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 Non-MTUS Citation: Official Disability Guidelines (ODG), Infectious Disease Chapter, Ciprofloxacin (CIPROÂ®).

Decision rationale: The California Medical Treatment Utilization Schedule does not address antibiotic usage. The Official Disability Guidelines support the use of this medication for multiple types of infections. It is considered a first line treatment. However, the clinical documentation submitted for review does not provide any evidence of infection that would benefit from the use of an antibiotic. No justification or physical exam findings were provided to support this request. A medication history was not provided. As such, the requested Ciprofloxacin 500 mg, Qty: 10, 5 Day Supply is not medically necessary or appropriate.