

Case Number:	CM14-0136794		
Date Assigned:	09/03/2014	Date of Injury:	07/24/2013
Decision Date:	09/30/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/25/2014

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 Emergency Medicine and Fellowship, 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 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 female who reported an injury on 07/24/2013. The mechanism of injury reportedly occurred when an automatic door closed on the injured worker. The injured worker's diagnoses included lumbar musculoligamentous sprain with lower extremity radiculitis, right shoulder impingement, acromioclavicular degenerative joint disease, left shoulder periscapular strain and right sprain ankle. Prior treatment included 12 acupuncture treatments and 12 sessions of physiotherapy. Diagnostic studies included an ultrasound of the right shoulder which was performed on 11/20/2013 and an MRI of the lumbar spine which was performed on 10/16/2013. The injured worker's surgical history was not provided in the medical records. The injured worker complained of bilateral shoulder and low back pain. The clinical note dated 05/27/2014 noted the injured worker's pain level was rated 7/10. There was tenderness to palpation to the right shoulder. Range of motion and strength in the right shoulder were decreased. Medications included Zofran. The physician recommended the injured worker undergo surgical intervention to the right shoulder. The treatment plan included a request for Zofran ODT quantity 10 and Keflex on quantity 30. The rationale for the requests was not provided. The request for authorization was not provided within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zofran ODT #10: 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, Antiemetics (for opioid nausea).

Decision rationale: The request for Zofran ODT #10 is not medically necessary. Within the provided documentation, the physician recommended the injured worker undergo surgical intervention to the shoulder. The Official Disability Guidelines do not recommend Zofran for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with use of opioids and these side effects tend to diminish over days to weeks of continued exposure. Zofran is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment, for postoperative use, and acute use is FDA-approved for gastroenteritis. The physician recommended surgery for the right shoulder; however, there is no indication that the surgery is approved and scheduled within the near future. There is no indication that the injured worker is experiencing symptoms of nausea or vomiting for which the medication would be recommended. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request failed to provide the frequency of symptoms to support Zofran to be utilized. Therefore, the request is not medically necessary.

FKelex one #30: 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 Diseases, Cephalexin (Keflex®).

Decision rationale: The request for Keflex on#30 is not medically necessary. Within the provided documentation, the physician recommended the injured worker undergo surgical intervention to the shoulder. The Official Disability Guidelines recommend Keflex as a first-line treatment for cellulitis and other conditions. For outpatients with non-purulent cellulitis, empirical treatment for infection due to beta-hemolytic streptococci and methicillin-sensitive *S. aureus*, cephalexin 500 mg QID is recommended. The physician recommended surgery for the right shoulder; however, there is no indication that the surgery is approved and scheduled within the near future. There is no evidence that the injured worker currently has an infection for which Keflex would be indicated. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request failed to provide the location, current status of the soft tissue infection and whether it was healing. Therefore, the request is not medically necessary.