

Case Number:	CM15-0147767		
Date Assigned:	08/10/2015	Date of Injury:	07/12/2000
Decision Date:	09/15/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/29/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 36 year old female, who sustained an industrial injury on July 12, 2000, incurring neck, right shoulder, right elbow, right wrist and right hand injuries. She was diagnosed with impingement syndrome of the right shoulder, bicipital tendonitis, impingement syndrome of the left shoulder, rotator cuff tear, right epicondylitis, right wrist inflammation and cervical strain. Treatment included physical therapy, shoulder injections, hot and cold wraps, bracing, gel collar, neck traction, and transcutaneous electrical stimulation unit and activity restrictions. Currently, the injured worker complained of right shoulder pain. Upon examination, the right shoulder revealed a positive impingement sign, tenderness, limited range of motion and loss of strength. She was diagnosed with a right shoulder impingement syndrome and required a right biceps tendon release and stabilization. The treatment plan that was requested for authorization included surgical service for Polar Care for 21 days and prescriptions for post-operative Augmentin, post-operative Neurontin and post-operative Zofran.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Polar Care x 21 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately post-operatively for up to 7 days. In this case the requested duration exceeds the guideline recommendations and the request is therefore not medically necessary.

Post-op Augmentin 875/125 #40: 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): Infectious Diseases (online version).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Stulberg DL, Penrod MA, Blatny RA, Common bacterial skin infections, Am Fam, Physician. 2002 Jul 1; 66 (1): 119-24.

Decision rationale: CA MTUS/ACOEM and ODG are silent on the issue of Augmentin. An alternative guideline was utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119-125, titled "Common Bacterial Skin Infections", Augmentin is for skin wounds and skin infections. It was found from a review of the medical record submitted of no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Augmentin is therefore not medically necessary and appropriate.

Post-op Neurontin 600mg #180: 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): Pain (online version), Anti-epilepsy drugs (AEDs) for pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy Page(s): 18.

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam notes do not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore, the request is not medically necessary.

Post-op Zofran 8mg #20: 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): Pain (online version), 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) pain.

Decision rationale: CA MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. In this case the submitted records demonstrate no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore, the request is not medically necessary.