

<b>Case Number:</b>	CM15-0072120		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	05/24/2011
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	04/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 70 year old male who sustained an industrial injury on 5/24/11. The injured worker reported symptoms in the right hip and right lower extremity. The injured worker was diagnosed as having hip joint inflammation, femur fracture status post multiple surgeries discogenic lumbar condition, left shoulder impingement and chronic pain. Treatments to date have included physical therapy, cane, heat/cold wrap, transcutaneous electrical nerve stimulation unit, activity modification, oral pain medication and injections. Currently, the injured worker complains of pain in the right hip and right knee. The plan of care was for medication prescriptions and a follow up appointment at a later date. The patient sustained the injury due to fall. The medication list include Fenoprofen, Pantoprazole, Flexeril, Tramadol, Zofran and Neurontin. The patient's surgical history include femur surgery in 8/11/11 and the patient has had post op infection and removal of hardware. The past medical treatment includes TKR. The patient has had MRI of the left shoulder that revealed impingement, and degenerative changes. Patient has received an unspecified number of PT visits for this injury. The patient had received ESI for this injury. The patient has used a TENS unit. Per the doctor's note dated 3/24/15 patient had complaints of right hip tightness and fatigue. Physical examination revealed tenderness on palpation. Physical examination of the shoulder on 3/10/15 revealed tenderness on palpation, positive impingement sign, and limited range of motion and weakness.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Amoxicillin 875mg #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 DGO, Infectious Diseases, Methicillin-resistant staphylococcus aureus (MRSA).

**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 (updated 11/11/14) c) Amoxicillin (Amoxil).

**Decision rationale:** As per cited guideline the medication Amoxicillin recommended as first-line treatment for cellulitis and other conditions. Evidence of cellulitis or other infectious conditions was not specified in the records provided. Rationale for the use of Amoxicillin 875mg #40 was not specified in the records provided the medical necessity of the request for Amoxicillin 875mg #40 is not fully established in this patient.

**Purchase of shoulder immobilizer:** 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), Postoperative abduction pillow sling.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 05/04/15) Postoperative abduction pillow sling Immobilization.

**Decision rationale:** Purchase of shoulder immobilizer: ACOEM and CA MTUS chronic pain guidelines do not address this request. Therefore ODG was used. Per the cited guidelines, not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. With the shoulder, immobilization is also a major risk factor for developing adhesive capsulitis, also termed "frozen shoulder." As per cited guideline immobilization of the shoulder is not recommended as a primary treatment and is a major risk factor for developing adhesive capsulitis, or frozen shoulder. Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. Any evidence of recent shoulder surgery was not specified in the records provided. As per cited guideline, postoperative abduction pillow sling: Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. (Ticker, 2008). Any surgery or procedures related to this injury were not specified in the records provided. Any operative note was not specified in the records provided. Any evidence that the patient was certified for a right shoulder surgery was not specified in the records provided. In addition as per cited guideline, the

immobilization devices decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. The medical necessity of the request for Purchase of shoulder immobilizer for the right shoulder is not fully established for this patient.

**Gabapentin 600mg #180:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18.

**Decision rationale:** Gabapentin 600mg #180. According to the CA MTUS Chronic pain guidelines regarding Neurontin/ gabapentin, has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Spinal cord injury: Recommended as a trial for chronic neuropathic pain. Lumbar spinal stenosis: Recommended as a trial, with statistically significant improvement found in walking distance, pain with movement, and sensory deficit. This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid. The injured worker was diagnosed as having hip joint inflammation, femur fracture status post multiple surgeries discogenic lumbar condition, left shoulder impingement and chronic pain. Currently, the injured worker complains of pain in the right hip and right knee. The patient's surgical history includes femur surgery in 8/11/11 and the patient has had post op infection and removal of hardware. The past medical treatment include TKR. The patient has had MRI of the left shoulder that revealed impingement, and degenerative changes. Per the doctor's note dated 3/24/15 patient had complaints of right hip tightness and fatigue. Physical examination revealed tenderness on palpation. The patient has chronic pain. The patient has abnormal objective findings that are consistent with the patient symptoms. Anticonvulsants or anti-epileptics like gabapentin / Neurontin are medically appropriate and necessary in this patient. The cited guidelines support the use of Gabapentin 600mg quantity 600 in patients with this clinical situation therefore the request is deemed medically necessary.