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| Case Number: | CM14-0103942 | | |
| Date Assigned: | 07/30/2014 | Date of Injury: | 02/15/2012 |
| Decision Date: | 09/03/2014 | UR Denial Date: | 06/27/2014 |
| Priority: | Standard | Application Received: | 07/05/2014 |

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 Orthopedic Surgery 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 claimant is a 44-year-old gentleman who sustained an injury to the right shoulder in a work-related accident on February 15, 2012. The records available for review document a history of shoulder dislocation at the time of injury. The report of a May 14, 2014, MR arthrogram revealed chronic anterior-inferior dislocation with articular cartilage loss of the humeral head. A follow-up report dated January 30, 2014, notes continuing restricted range of motion as a result of chronic pathology. Physical examination of the right shoulder showed 85 degrees of flexion, 20 degrees of extension and absent external rotation. There was noted weakness with external rotation at 4/5, tenderness to palpation, significant deltoid atrophy and a prominent lateral acromion and supracromioclavicular space. The claimant's working diagnosis was documented as chronic anterior-inferior dislocation with a scapular body fracture to the right shoulder. Imaging was reviewed at that office visit and documented that plain-film radiographs showed soft-tissue calcification and chronic inferior dislocation. Heterotopic bone formation of the coracoid process was noted. Y-view radiographs of the right shoulder revealed an anterior dislocation of the shoulder. Based on chronic clinical findings, this request is for: a right shoulder open reduction with capsular lysis and excision of heterotopic bone; pre-operative medical consultation and evaluation; Xanax; a compound cream containing Ketoprofen, cyclobenzaprine and Lidocaine; Anaprox; and Prilosec.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder open reduction and capsular lysis with excision of heterotropic bone, outpatient: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: Based on California MTUS ACOEM Guidelines, the request for right shoulder open reduction and capsular lysis with excision of heterotropic bone, as an outpatient would not be indicated in this case. Under ACOEM Guidelines, surgery is indicated when the clinical presentation includes activity limitations and physical and imaging evidence of a lesion that is shown to benefit in both the short- and long-term from surgical repair. This claimant has a chronic, sublux/dislocated right shoulder that have failed nearly three years of conservative care. The reviewed records document a fixed deformity of the shoulder with documentation of significant calcific findings and heterotopic bone. The documents reference no factor that would indicate the role of heterotopic bone removal or indication for surgical treatment of subluxation subacutely. Given the claimant's clinical presentation, imaging findings and lack of significant progress with function over the course of the past two years, the requested acute surgical intervention would not be established as medically necessary.

Pre-op Internal medicine consult/evaluation for surgical clearance: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Xanax 0.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: California MTUS Chronic Pain Guidelines would not support the continued use of Xanax in this case. The Chronic Pain Guidelines recommend that benzodiazepines are only indicated for short-term use of two to four weeks for the management of an acute,

symptomatic flare. Given the chronic nature of the claimant's presentation and absent documentation of an acute flare, this request would not be established as medically necessary.

Compound cream ketoprofen 10%, cyclobenzaprine 3%, lidocaine 5%, 120grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: California MTUS Chronic Pain Guidelines would not support the use of a topical compound containing Ketoprofen, Cyclobenzaprine and Lidocaine. Under the Chronic Pain Guidelines, any topical compounding agent that contains an agent that is not supported would fail to support use of the agent as a whole. Due to a high instance of photosensitivity dermatitis, ketoprofen is a non-FDA approved agent for topical use. Chronic Pain Guidelines also do not support the use of muscle relaxants in the form of Cyclobenzaprine. Finally, the use of lidocaine is only indicated as a second-line option for neuropathic pain. Given these factors, this request would not be medically indicated.

Anaprox 500mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67, 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: The California MTUS Chronic Pain Guidelines would not support the continued use of Anaprox in this case. The Chronic Pain Guidelines recommend that non-steroidal medication should be utilized at the lowest dose possible for the shortest period of time possible and that non-steroidal medications are not recommended for long-term chronic use without documentation of symptomatic flare. In this case, the reviewed records contain no documentation of acute clinical findings or acute symptomatic complaints. Given the timeframe from injury and absence of acute presentation, this request would not be established as medically necessary.

Prilosec 20mg #60: Upheld

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 Prilosec: NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The California MTUS Chronic Pain Guidelines would not support continued use of Prilosec in this case. The reviewed records do not document significant risk factor for gastritis, and the request for continued use of non-steroidal medications, which would be an indication for the use of a protective proton pump inhibitor, has not been established as medically necessary. Therefore, this request is not supported as medically necessary.