

<b>Case Number:</b>	CM14-0012355		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	08/09/2013
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	01/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 patient is a 38-year-old female who has filed a claim for left shoulder AC joint arthrosis associated with an industrial injury date of August 09, 2013. The progress notes indicate left shoulder pain with minimal improvement from the injection, and low back pain. Findings include decreased left shoulder range of motion; decreased strength of left hand grip; decreased lumbar range of motion with tenderness, spasms, and trigger points; and positive bilateral straight leg raise test; and inability to perform heel-toe walk. An MRI of the left shoulder dated August 20, 2013 showed focal tendinosis and/or partial intrasubstance tearing within the deep fibers of the distal supraspinatus tendon at its attachment to the humeral head; no full thickness rotator cuff tear; minimal AC joint hypertrophy without narrowing of the coracoacromial arch; and tiny amount of fluid in the subacromial bursa, which may represent bursitis. MRI of the lumbar spine dated September 13, 2013 showed L5-S1 disc bulge with bilateral exiting nerve root compromise. Treatment to date has included NSAIDs, opioids, topical analgesics, sedatives, physical therapy, and injection to the left shoulder. A utilization review from January 10, 2014 denied the requests for left shoulder arthroscopic subacromial decompression and partial claviclectomy as there was no documentation of failure of all conservative management strategies or of findings of impingement or AC disease; Xanax 1mg #30 as its use in chronic pain is not appropriate; and Prilosec 20mg #90 as there was no documentation of GI risk factors.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRILOSEC 20 MG QUANTITY 90:** 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 : NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** According to page 68 of the MTUS Chronic Pain Guidelines, proton pump inhibitors are used in patients on NSAID therapy who are at risk for GI events. Risk factors include age > 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. The patient has been on this medication since September 2013. In this case, the patient does not present with any of the abovementioned risk factors, or with upper GI symptoms. As such, the request is not medically necessary and appropriate.

**XANAX 1 MG QUANTITY 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** As noted on page 24 of the MTUS Chronic Pain Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The patient has been on this medication since September 2013 for sleep. However, there is no documentation of sleep issues in the recent progress notes. Also, this medication is not indicated for chronic use. Therefore, the request for Xanax 1mg #30 is not medically necessary.

**LEFT SHOULDER ANTHROSCOPIC SUBRACROMIAL DECOMPRESSION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Surgery for impingement syndrome.

**Decision rationale:** The ODG criteria for arthroscopic decompression (acromioplasty) include 3-6 months of conservative care; subjective findings - pain with active arc motion at 90-130 degrees and pain at night; objective findings - weak or absent abduction or atrophy, tenderness over rotator cuff or anterior acromial area, and positive impingement sign with temporary relief with anesthetic injection; and positive imaging findings of impingement. In this case, there is no

documentation regarding pain with overhead activities, pain at night, or positive impingement signs on examination. MRI results did not show impingement as well. Therefore, the request for left shoulder arthroscopic subacromial decompression is not medically necessary.

**PARTIAL DISTAL CLAVICLECTOMY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Partial claviclectomy (Mumford procedure).

**Decision rationale:** According to the ODG, indications for partial claviclectomy (includes Mumford procedure) includes at least 6 weeks of conservative care; subjective findings of pain at AC joint, aggravation of pain with shoulder motion or carrying weight, or previous grade I or II AC separation; objective findings of tenderness over the AC joint and/or pain relief obtained with an injection; and imaging findings showing post-traumatic changes of AC joint, severe DJD of AC joint, or complete/incomplete separation of AC joint, with positive bone scan for AC joint separation. In this case, there is no description of the shoulder pain as noted above or findings of tenderness over the AC joint. A previous injection only afforded minimal improvement. MRI findings showed minimal AC joint hypertrophy. At this time, the indications for this procedure have not been met. Therefore, the request for partial distal claviclectomy is not medically necessary.