MAXIMUS Federal Services

Case Number:	CM14-0045323		
Date Assigned:	06/27/2014	Date of Injury:	01/17/2013
Decision Date:	07/29/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/01/2014

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:

This 57-year-old male foreman sustained an industrial injury on 1/17/13. Injury was sustained when he lost his footing while holding a hot tar mop, and fell backwards from a 2-story roof landing on his face and right shoulder. Diagnoses included brain hemorrhage, facial and skull fractures, loss of teeth, rib fractures, right shoulder dislocation and burns to the forearms and chest. He was hospitalized for four months. The 12/30/13 right shoulder MRI documented partial thickness tears of the supraspinatus and infraspinatus, supraspinatus and infraspinatus tendinopathy, type III acromion with an enthesophyte, subdeltoid bursal edema, and benign bony lesion at the anterior base of the scapular spine. The 2/21/14 treating physician report cited moderate to severe right shoulder pain with profound limitations. Right shoulder exam findings documented acromioclavicular (AC) joint and subacromial tenderness, flexion 170 degrees, abduction 160 degrees, and positive Neer's, Hawkin's, cross chest, and AC joint compression tests. The treatment plan requested authorization for right shoulder arthroscopic acromioplasty with distal claviculectomy. Associated medications and services were also requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec DR 20MG #60 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The California MTUS guidelines recommend the use of proton pump inhibitors (PPIs), such as Prilosec, for patients at risk for gastrointestinal events. Risk factors include age greater than 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). PPIs are reported highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Guideline criteria for intermediate gastrointestinal risk factors have been met. Records indicate that this patient has been prescribed low-dose aspirin in addition to Anaprox. Therefore, this request for Prilosec DR 20MG #60 with 2 refills is medically necessary.

1 cold therapy unit: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Shoulder, Continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding continuous flow cryotherapy. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The 3/13/14 utilization review partially certified a cold therapy unit for 7 days use consistent with guidelines. There is no compelling reason presented to support the medical necessity of continuous flow cryotherapy is excess of guideline recommendations. Therefore, this request for one cold therapy unit is not medically necessary.

1 continuous passive motion rental unit for 21 days: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Shoulder, Continuous passive motion (CPM).

Decision rationale: The California MTUS are silent regarding continuous passive motion units. The Official Disability Guidelines do not recommend continuous passive motion unit for rotator cuff problems. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have not been met. There is no evidence that this patient has adhesive capsulitis. Therefore, this request for one continuous passive motion rental unit for 21 days is not medically necessary.

1 pain pump: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Shoulder, Postoperative pain pump.

Decision rationale: The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. Given the absence of guideline support for the use of post-operative pain pumps, this request for a pain pump is not medically necessary.

Sprix Spray: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain (Chronic), Sprix (ketorolac tromethamine nasal spray).

Decision rationale: The California MTUS guidelines are silent regarding Sprix spray. The Official Disability Guidelines recommend ketorolac tromethamine (Sprix Nasal Spray) for the short-term management of moderate to moderately severe pain requiring analgesia at the opioid level. The total duration of use of this intranasal formulation, as with other ketorolac formulations, should be for the shortest duration possible and not exceed 5 days. The 3/13/14 utilization review partially certified the request for Sprix spray for up to 5 days use. There is no compelling reason presented to support the medical necessity of this medication beyond guideline recommendations and prior certification. Therefore, this request for Sprix spray is not medically necessary.