

Case Number:	CM15-0145386		
Date Assigned:	08/06/2015	Date of Injury:	10/22/2008
Decision Date:	09/02/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/27/2015

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: North Carolina

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 40 year old male who sustained an industrial injury on October 22, 2008. The injured worker was employed as order filler who sustained acute onset of pain while moving 50 pound bags of Calcite. He stated having felt his left arm drop down a bit with immediate onset of pain. On August 14, 2009, the injured worker underwent a diagnostic arthroscopy of the left shoulder. On August 02, 2011, he underwent a functional capacity evaluation. An orthopedic follow up visit dated February 05, 2013 reported subjective complaint of persistent left shoulder pain. Current medications are: Flexeril, Norco 10 mg 325 mg. Active problems were: joint derangement shoulder, and superior glenoid labrum lesion. The assessment found the injured worker with osteoarthritis of the left shoulder; osteoarthritis of the left shoulder acromioclavicular joint; left anterior glenoid labrum lesion, and sprained left superior glenoid labrum lesion. The plan of care noted continuing with home exercise program and stretching, Norco, and Flexeril. There is also recommendation to purchase a new home cervical traction unit. He is to remain permanently disabled. A more recent orthopedic follow up dated June 24, 2015 reported unchanged subjective complaint. There is mention of denial for a cervical traction unit. The plan of care noted recommending Orthovisc injections for the left shoulder complaints. He is to continue utilizing the transcutaneous nerve stimulator unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 series of 3 Orthovisc injections for the left shoulder: 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, Hyaluronic Acid Injections.

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

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. Per the ODG section on hyaluronic acid injections, criteria for injections include patients who experience significantly symptomatic osteoarthritis without adequate response to conservative non-pharmacological and pharmacological treatments; documented symptomatic severe osteoarthritis pain interferes with functional activities, failure to respond to aspiration and injection of intra-articular steroids, not candidates for surgery. The patient does not have the diagnosis of osteoarthritis and therefore the request is not medically necessary.

Unknown prescription of Celebrex: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68-72.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID use and proton pump inhibitors (PPI) states: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Cardiovascular disease: A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short-term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxyn plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-

dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxyn is ineffective, the suggested treatment is (1) the addition of aspirin to naproxyn plus a PPI, or (2) a low-dose Cox-2 plus ASA. Cardiovascular risk does appear to extend to all non-aspirin NSAIDs, with the highest risk found for the Cox-2 agents. (Johnsen, 2005) (Lanas, 2006) (Antman, 2007) (Laine,2007) Use with Aspirin for cardioprotective effect: In terms of GI protective effect: The GI protective effect of Cox-2 agents is diminished in patients taking low-dose aspirin and a PPI may be required for those patients with GI risk factors. (Laine, 2007)In terms of the actual cardioprotective effect of aspirin: Traditional NSAIDs (both ibuprofen and naproxen) appear to attenuate the antiplatelet effect of enteric-coated aspirin and should be taken 30 minutes after ASA or 8 hours before. (Antman, 2007) Cox-2 NSAIDs and diclofenac (a traditional NSAID) do not decrease anti-platelet effect. (Laine, 2007) Per the California MTUS guidelines, Cox-2 agents like Celebrex are indicated for patients at intermediate or high gastrointestinal risk. While the patient has had non-specific GI complaints, there are no documented risk factors that place the patient at intermediate or high risk as set forth above. Therefore, the medication does not meet criteria and is not medically necessary.