

Case Number:	CM13-0037110		
Date Assigned:	12/13/2013	Date of Injury:	04/21/2010
Decision Date:	03/18/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	10/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 patient is a 32-year-old male who sustained work related injuries to the shoulder and neck on 04/21/10. An MRI of the cervical spine dated 02/25/12 demonstrated a posterior disk osteophyte complex at C7-T1. MRI of the right shoulder demonstrated a downsloping partial bursal surface tear of the supraspinatus. Patient underwent right shoulder arthroscopy and subacromial decompression (SAD) with limited synovectomy on 09/16/10. The patient continued to have persistent shoulder pain and updated MRI of the right shoulder dated 08/30/11 demonstrated a full thickness tear of the supraspinatus. The patient then underwent right shoulder SAD and rotator cuff repair on 11/10/11. Additional conservative treatment has consisted of pain medications, physical therapy, injections, and work hardening. On 09/03/13, the Treating Physician discontinued the patient's tramadol and switched the medication to Hydrocodone. The patient has also continued to use Naproxen. Physical examination on 09/24/13 reveals the patient's skin is within normal limits except for scarring to the right shoulder. Lumbar and cervical spasms are noted. There is tenderness to palpation of the lumbar paraspinal muscles overlying bilateral L3-S1 facet joints and cervical paraspinal muscles overlying bilateral C5-T1 facet joints. Tenderness to palpation is also noted over the right deltoid. Range of motion (ROM) is restricted by pain in all directions in the right shoulder, lumbar and cervical spine. Lumbar and cervical facet provocative maneuvers are positive. Lumbar and cervical extension is worse than flexion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 5/325mg #90 dispensed on 9/24/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 92-94.

Decision rationale: Documentation provided notes that the patient sustained injury to the shoulder and neck in 2010. Physical examination reveals restricted ROM due to pain in all planes tested in the right shoulder, lumbar and cervical spine. Per CA-MTUS Guidelines if the patient has returned to work or if the patient has improved functioning and pain opioids may be continued. On 09/03/13, the Treating Provider discontinued the patient's tramadol and switched the medication to hydrocodone. However, on follow up evaluation on 09/24/13, there is no mention of a response to the switch to hydrocodone. There is no mention of decreased pain or increased function. Thus, the medical documentation provided does not support the medical necessity for continued use of hydrocodone.

Naproxen 550mg #60 dispensed on 9/24/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: The MTUS guidelines indicate that NSAIDs are recommended for osteoarthritis of the hip and knee, and are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Follow up evaluations of this patient make no mention of a response to the naproxen. There is no mention of decreased pain or increased function. Thus, the medical documentation provided does not support the medical necessity for continued use of naproxen and the request is not medically necessary.