

<b>Case Number:</b>	CM14-0007947		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	08/09/2013
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	01/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/17/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 sustained a work injury on 08/09/13 when he lost his balance while exiting his truck, slipping and falling 4 feet. He had right shoulder and back pain. Although there is reference to a right scapular fracture this is not substantiated by imaging findings. An MRI of the right shoulder in October 2013 with a clinical history of possible fracture included findings of a partial rotator cuff tear, acromioclavicular arthritis, mild labral degeneration and calcific tendinitis/bursitis. There were no bone abnormalities. Treatments included physical therapy and a subacromial injection without improvement. He was seen by the requesting provider on 01/24/14. He was having ongoing right shoulder pain radiating to the mid back. Physical examination findings included decreased right shoulder range of motion with tenderness and muscle spasms and positive impingement testing. Imaging results were reviewed. Authorization for physical therapy 2-3 times per week for six weeks was requested. There was consideration of an open rotator cuff repair. Hydrocodone/acetaminophen #120 was refilled. On 03/07/14 his condition was unchanged. Treatments had included physical therapy with TENS. Authorization for acupuncture and for a right shoulder injection was requested. He was continued at modified work with restrictions of lifting up to 20 pounds and no overhead work on the right side. Hydrocodone/acetaminophen #120 was refilled.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 10/325mg:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Hydrocodone/Acetaminophen .

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use Page(s): 76-80.

**Decision rationale:** The claimant is more than one year status post work-related injury and continues to be treated for chronic right shoulder pain due to impingement with imaging findings showing a partial rotator cuff tear, acromioclavicular arthritis, mild labral degeneration and calcific tendinitis/bursitis. The claimant has been released to work with reasonable restrictions and limitations. In this case, the claimant is expected to have somewhat predictable activity-related breakthrough pain (i.e. incident pain) when using his right upper extremity which is consistent with his history of injury and imaging findings. Hydrocodone 10/325 mg is a short-acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There are no identified issues of abuse, addiction, or poor pain control. There are no inconsistencies in the history, presentation, the claimant's behaviors, or by physical examination. Therefore, the continued prescribing of Hydrocodone 10/325 mg was medically necessary.

**Naproxen 550mg:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, Specific Drug List & Adverse Effects Page(s): 73. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6, page 91

**Decision rationale:** The claimant is more than one year status post work-related injury and continues to be treated for chronic right shoulder pain due to impingement with imaging findings showing a partial rotator cuff tear, acromioclavicular arthritis, mild labral degeneration and calcific tendinitis/bursitis. The claimant has been released to work with reasonable restrictions and limitations. Oral NSAIDS (non-steroidal anti-inflammatory medications) are recommended for treatment of chronic persistent pain as in this case. Dosing of Naproxen is 275-550 mg twice daily and the maximum daily dose should not exceed 1100 mg. In this case, the requested strength (550 mg) is within the recommended dosing guidelines and therefore medically necessary.