MAXIMUS Federal Services

Case Number:	CM14-0108566		
Date Assigned:	08/01/2014	Date of Injury:	04/24/2007
Decision Date:	08/29/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/14/2014

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 Pain Management and Rehabilitation and is licensed to practice in Texas. 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 injured worker is a 53 year old female who sustained a work related injury on 04/24/07. Mechanism of injury is undisclosed. Most recent clinical documentation submitted for review dated 04/17/14 the injured worker returned with persistent right shoulder pain 7/10 in severity, burning stabbing type. She reported having upset stomach with Hydrocodone. She had reflux associated with Hydrocodone therefore requesting different pain medication. Lactulose helped constipation associated with medication. Electromyography and nerve conduction studies (EMG/NCS) of bilateral upper extremities on 02/07/13 showed right median neuropathy at the wrist, mild in severity with no evidence of cervical radiculopathy. She was status post right shoulder rotator cuff repair on 09/10/09. The injured worker had right shoulder arthrogram on 01/19/10 due to persistent right shoulder pain; which showed status post acromioplasty without residual impingement or deltoid release. No evidence of recurrent full thickness tear, no labral tear, irregularity of the articular surface fibers in the supraspinatus and infraspinatus tendon which may have represented a partial tear of postsurgical changes. On physical examination; she was alert, oriented, and pleasant to work with, pulses 80 blood pressure 125/76 weight 188 pounds; musculoskeletal, negative for joint swelling and stiffness, neurological positive for headaches, positive for anxiety and depression, grossly protective of her right upper extremity, spasm was noted in the right shoulder musculature, tender in the anterior aspect of right shoulder more so on the right acromioclavicular joint, right shoulder abduction and forward flexion was 100 degrees associated with pain and discomfort, strength was 4/5 in the right shoulder abduction and forward flexion. Otherwise no gross changes noted. Diagnosis right shoulder impingement syndrome, myofascial pain, right shoulder adhesive capsulitis, status post right shoulder surgery. Prior utilization review on 06/27/14 was noncertified. In review of clinical

documentation submitted, there were no visual analog scale (VAS) scores with and without medication. No clinical documentation of functional improvement. No urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg, qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80, 93, 94, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid's Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Opioid's.

Decision rationale: The request for Tramadol 50 milligrams quantity 60 is not medically necessary. Current evidenced based guidelines indicate patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. In review of clinical documentation submitted, there was no visual analog scale (VAS) scores with and without medication. No clinical documentation of functional improvement. No urine drug screen. As such medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician. Therefore, this request is not medically necessary.

Lactulose (dose and quantity unknown): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Opioid-induced constipation treatment.

Decision rationale: The request for Lactulose (dose and quantity unspecified) is predicated on the initial request for Tramadol. As this has not been found to be medically necessary, the subsequent request is not medically necessary.