

Case Number:	CM15-0082047		
Date Assigned:	05/04/2015	Date of Injury:	06/21/2012
Decision Date:	06/04/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	04/29/2015

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: Texas, Florida, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 47 year old male with an industrial injury dated 6/21/2012. The injured worker's diagnoses include status post right shoulder scope (shoulder subacromial decompression) SAD; biceps tenotomy and history right shoulder scope SLAP (superior labral anterior and posterior) repair dated 11/2/2012. Treatment consisted of MR arthrogram right shoulder, prescribed medications, physical therapy and periodic follow up visits. In a progress note dated 2/25/2015, the injured worker reported anterolateral and posterior shoulder discomfort with repetitive activities. Objective findings revealed tenderness to palpitation of supraspinatus anterior capsule and mild tenderness of the acromioclavicular joint (AC) and infraspinatus. The treating physician noted that the MR arthrogram revealed post op status SLAP repair, biceps tenotomy, debridement and minimal rotator cuff (RC) fraying about the supraspinatus. The treating physician prescribed an alternative NSAID trial of Zorvolex 35 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zorvolex 35 mg #30 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. and ODG, pain section, under Diclofenac Page(s): 67.

Decision rationale: Zorvolex is the same as Diclofenac. The MTUS recommends non-steroidal anti-inflammatory drugs (NSAID) medication such as Diclofenac for osteoarthritis, at the lowest dose, and the shortest period possible. The use here appears chronic, with little information in regards to functional objective improvement out of the use of the prescription Naproxen. Further, the guides cite that there is no reason to recommend one drug in this class over another based on efficacy. It is not clear why a prescription variety of NSAID would be necessary; therefore, when over the counter NSAIDs would be sufficient. There is no evidence of long-term effectiveness for pain or function. This claimant though has been on some form of a prescription non-steroidal anti-inflammatory medicine for some time, with no documented objective benefit or functional improvement. The MTUS guideline of the shortest possible period of use is clearly not met. Without evidence of objective, functional benefit, such as improved work ability, improved activities of daily living, or other medicine reduction, the MTUS does not support the use of this medicine. It is appropriately non-certified. Also, regarding Diclofenac, the ODG notes: Not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid diclofenac because it increases the risk by about 40%. There was no documentation of the dosing schedule and there is no documentation of functional improvement from prior use to support its continued use for the several months proposed. Moreover, it is not clear if the strong cardiac risks were assessed against the patient's existing cardiac risks. The request was appropriately not medically necessary.