

<b>Case Number:</b>	CM13-0008266		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/10/2011
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	07/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2013

### 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 and is licensed to practice in Illinois. 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 33-year-old female who reported an injury on 09/10/2011. The mechanism of injury was not stated. Current diagnoses include right shoulder impingement syndrome, right AC cartilage disorder, right supraspinatus tendinosis, right subacromial subdeltoid bursitis, and right bicipital tendinitis. The injured worker was evaluated on 07/02/2013. The injured worker reported 7/10 pain in the right shoulder. Physical examination revealed limited right shoulder range of motion and decreased grip strength on the right. Treatment recommendations at that time included a subacromial corticosteroid injection into the right shoulder, physical therapy twice per week for 6 weeks, acupuncture therapy twice per week for 6 weeks, and a refill of Naprosyn 550 mg, omeprazole 20 mg, and tramadol 50 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **RIGHT SHOULDER SUBACROMIAL STERIOD INJECTION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** The California MTUS ACOEM Practice Guidelines state invasive techniques have limited proven value. If pain with elevation significantly limits activities, a

subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy for 2 to 3 weeks. As per the documentation submitted, there is no evidence of significant activity limitation. There is also no documentation of an attempt at conservative therapy including strengthening exercises. Therefore, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary or appropriate.

**PHYSICAL THERAPY 2 X PER WEEK X 6 WEEKS: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Treatment for unspecified myalgia and myositis includes 9 to 10 visits over 8 weeks. The current request for 12 sessions of physical therapy exceeds guideline recommendations. There is also no specific body part listed in the current request. As such, the request is not medically necessary or appropriate.

**ACUPUNCTURE 2 X 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. Therefore, the current request for 12 sessions of acupuncture exceeds guideline recommendations. There is also no specific body part listed in the current request. As such, the request is not medically necessary or appropriate.

**TRAMADOL 50MG #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects

should occur. There is no evidence of objective functional improvement as a result of the ongoing use of this medication. There is also no frequency listed in the current request. As such, the request is not medically necessary or appropriate.

**NAPROSYN 550MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There is no documentation of objective functional improvement as a result of the ongoing use of this medication. There is also no frequency listed in the current request. As such, the request is not medically necessary or appropriate.

**OMEPRAZOLE 70MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitor Page(s): 68-69.

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency listed in the current request. Therefore, the request is not medically necessary or appropriate.