

<b>Case Number:</b>	CM13-0021467		
<b>Date Assigned:</b>	11/08/2013	<b>Date of Injury:</b>	05/04/2004
<b>Decision Date:</b>	03/12/2014	<b>UR Denial Date:</b>	08/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2013

### 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 Orthopedic Surgery and is licensed to practice in Arizona. 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 64-year-old male sustained an injury on 5/4/04 to both shoulders; he underwent nonsurgical treatment for a period of time without much relief of symptoms. On 1/25/06 he underwent left shoulder arthroscopy with subacromial decompression and a distal clavicle resection. He had physical therapy for about 1 year. He returned to work in 2008 and was laid off in 2009. He began complaining again of bilateral shoulder pain greater on the right than the left this was associated with limitation of motion and positive signs for impingement. The patient underwent right shoulder MRI which demonstrated a complete rotator cuff tear. In May 2013 the patient underwent arthroscopy of the right shoulder. He had a debridement of a partial tear of the rotator cuff and resection of the distal end of the clavicle with acromioplasty. His post-op course has been slow with continuing complaints of pain. The patient has been on Narco 10/325 twice a day since October 2010. It was increased to 3 times a day after the surgery. Because of the continuing complaints of pain in the left shoulder, the patient underwent an MRI arthrogram which revealed osteoarthritis of the acromioclavicular joint and no other abnormalities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy Sessions 3 X 4; Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention, Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** According to the treating physician, the range of motion of the patient's right shoulder has been inconsistent fluctuated at each visit. The shoulder strength has increased slowly. Pain relief has been inconsistent. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include the following categories: Work Functions and/or Activities of Daily Living, Self-Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS, etc.) Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees. Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. (California, 2007). For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. The amount and duration of physical therapy that the patient had since his injury, is not documented. In the functional improvement criteria are poorly documented and often illegible. Therefore, based on these factors the additional physical therapy is not deemed medically necessary.

**Orthopedic Consultation; Left Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM.

**Decision rationale:** This patient has been having pain in his left shoulder for a number of years and while clinically there was some thought given to a possible rotator cuff tear, the MR arthrogram showed no acute pathology in the shoulder except for mild osteoarthritis. Referral for surgical consultation may be indicated for patients who have: (1) Red-flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.); (2) Activity limitation for more than four months, plus existence of a surgical lesion; (3) Failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; (4) Clear clinical and imaging evidence of a lesion that has been shown to

benefit, in both the short and long term, from surgical repair. This patient does not demonstrate a surgical lesion nor does he have a red flag condition. Therefore, consultation with an

**Norco 10 mg, #60 with 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 Opioids Page(s): 74-96.

**Decision rationale:** This patient has chronic pain in his shoulder. Opioid dependence may be a factor in perpetuating his chronic pain. This patient needs to be in a self - management program addressing his chronic pain and the factors that may be influencing the pain. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000). Such as the use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control, documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). There is no or poor and illegible documentation on the level of functional improvement, pain relief, side effects, aberrant behavior in the medical record in reference to continue his use of Norco. There is no documentation of drug testing. Therefore, the continued use of Norco is not medically necessary.