

Case Number:	CM13-0038208		
Date Assigned:	12/18/2013	Date of Injury:	02/20/2002
Decision Date:	09/16/2014	UR Denial Date:	08/29/2013
Priority:	Standard	Application Received:	09/30/2013

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, has a subspecialty in Pain Management and is licensed to practice in California. 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:

This is a female patient with the date of injury of February 20, 2002. A Utilization Review was performed on September 8, 2013 and recommended modification of Physical Therapy (PT) 2x6 for bilateral shoulders to 6 PT sessions, Tylenol #3 #90, Prilosec 20mg #90, and Xanax 1mg #60. A Comprehensive Orthopedic re-evaluation dated June 6, 2013 identifies complaints of right shoulder hurts at 9/10 with a snapping and she is weak. Clinical examination identifies decreased right shoulder range of motion. Snapping with 3/4 pain in the biceps tendon, as well as in the acromioclavicular joint area and subacromial area on the right. Diagnoses identify cervical sprain/strain, right shoulder impingement with posttraumatic arthrosis of the acromioclavicular joint. Discussion and Recommendations identify physical therapy, renewal of all medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2 TIMES PER WEEK FOR 6 WEEKS FOR THE BILATERAL SHOULDERS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy 2 times per week for 6 weeks for the bilateral shoulders, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of 6 physical therapy sessions. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG goes on to recommend 10 physical therapy sessions. Within the documentation available for review, there is mention of right shoulder symptoms and findings. However, there is no identification of any left shoulder signs or symptoms. In addition, the requested number of sessions exceeds guidelines for an initial trial. In light of such issues, the current request for physical therapy 2 times per week for 6 weeks for the bilateral shoulders is not medically necessary and appropriate.

PRESCRIPTION OF TYLENOL #3, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79, 120.

Decision rationale: Regarding the request for Tylenol #3, California Pain Medical Treatment Guidelines state that Tylenol #3 is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Tylenol #3 is improving the patient's function or pain (in terms of percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. Unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Tylenol #3 is not medically necessary and appropriate.

PRESCRIPTION OF PRILOSEC 20MG, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASULAR RISK.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for Omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the

documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested Omeprazole is not medically necessary and appropriate.

PRESCRIPTION OF XANNAX 1MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Benzodiazepines.

Decision rationale: Regarding the request for Xanax (alprazolam), Chronic Pain Medical Treatment Guidelines state the benzodiazepines are not recommended for long-term use. Most guidelines limit their use to 4 weeks. Within the documentation available for review, it is unclear what diagnosis the Xanax is being prescribed to treat. There are no subjective complaints of anxiety or panic attacks. Furthermore, there is no documentation identifying any objective functional improvement as a result of the use of the Xanax. Finally, there is no indication that the Xanax is being prescribed for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Xanax is not medically necessary and appropriate.