

<b>Case Number:</b>	CM13-0052363		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	05/10/2012
<b>Decision Date:</b>	03/20/2014	<b>UR Denial Date:</b>	11/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/15/2013

### 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 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 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:

The patient is a 50-year-old female who reported a work-related injury on 5/10/12; she tripped and fell, causing injury to her left shoulder. The patient ultimately underwent rotator cuff repair and developed postoperative adhesive capsulitis. The patient underwent manipulation under anesthesia with capsulectomy followed by physical therapy and four work hardening visits. The patient's most recent clinical examination findings revealed range of motion of the left shoulder described as 155 degrees in flexion, 70 degrees in external rotation and internal rotation to the low back. Evaluation of the lumbar spine revealed range of motion described as 60 degrees in forward flexion, 25 degrees in extension, and 35 degrees in lateral bending. The patient's diagnoses included lumbar sprain/strain, backache, and impingement syndrome. The patient's treatment plan included refill of medications and continuation of physical therapy with a concentration on the lumbar back and core stabilization in combination with work hardening.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**acetaminophen 500mg four times a day:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11,60.

**Decision rationale:** The California MTUS recommends the use of acetaminophen for pain relief, but it also recommends that the continued use of any medication be supported by quantitative assessments of pain relief and functional improvement. The clinical documentation submitted for review fails to provide a quantitative assessment of pain relief related to medication usage. Therefore, the efficacy of this medication cannot be determined. Additionally, there is no documentation of functional benefit related to the patient's prescribed medications. As such, the requested acetaminophen is not medically necessary or appropriate.

**ibuprofen 800mg three times a day:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60,67.

**Decision rationale:** The California MTUS recommends the use of ibuprofen for pain relief, but it also recommends that the continued use of any medication be supported by quantitative assessments of pain relief and functional improvement. The clinical documentation submitted for review fails to provide a quantitative assessment of pain relief related to medication usage. Therefore, the efficacy of this medication cannot be determined. Additionally, there is no documentation of functional benefit related to the patient's prescribed medications. As such, the requested ibuprofen is not medically necessary or appropriate.

**physical therapy with work hardening twice a week for six weeks for the left shoulder and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99,125.

**Decision rationale:** The clinical documentation submitted for review indicates that the patient has continued deficits that would benefit from active therapy. However, the California MTUS recommends that work hardening programs be considered for patients who have progressed through a physical therapy program and reached a plateau. The clinical documentation submitted for review does not provide any evidence that the patient has reached a plateau in initial conservative therapy. Additionally, the clinical documentation does not include an adequate assessment of the patient's functional capabilities or a psychological assessment to support entrance into a work hardening program. As such, the requested physical therapy with work hardening is not medically necessary or appropriate.