

<b>Case Number:</b>	CM14-0123421		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	07/04/2013
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/04/2014

### 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 & 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 51-year-old female who reported an injury on 07/04/2013. The mechanism of injury was not provided within the medical records. The clinical note dated 07/08/2014 indicated diagnoses of status post subacromial decompression of the left shoulder and adhesive capsulitis of the left shoulder. The injured worker reported her condition to the left shoulder had deteriorated since her physical therapy. The injured worker reported she took Flexeril and used Vicodin for pain control. She reported she averaged 2 Vicodin a day. The injured worker reported she was able to do light housework, drive, grocery shop with help, and perform her own self-care. The injured worker felt that her shoulder condition had regressed because she was improving with physical therapy until that was stopped. The injured worker reported burning pain in the left shoulder area and reported the pain radiated down her arm with numbness and tingling in the small and ring fingers. The injured worker reported mild constant pain that increased with activity. On physical examination of the left shoulder there was tenderness in the acromioclavicular area and the subacromial area of the left shoulder. The injured worker was able to flex to 120 degrees with the help of her opposite arm, abduct to 110 degrees, extend to 20 degrees, adduct to 50 degrees, internal rotation to 60 degrees and external rotation to 60 degrees. The injured worker's prior treatments include a diagnostic imaging surgery and physical therapy and medication management. The provider submitted a request for Norco and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Weaning of Medications Page(s): 74-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list and Opioids, criteria for use Page(s): 91; 78.

**Decision rationale:** The request for Norco 5/325mg #30 is non-certified. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behaviors and side effects. In addition, it was not indicated how long the injured worker had been utilizing this medication. Moreover, the request did not indicate a frequency for this medication. Therefore, the request for Norco is non-certified.

**Physical Therapy QTY: 8 Left shoulder at 2x/wk for 4 weeks:** Upheld

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

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

**Decision rationale:** The request for Physical Therapy QTY: 8 Left shoulder at 2x/wk for 4 weeks is non-certified. The California MTUS state that 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. The guidelines note injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of documentation indicating the amount of physical therapy the injured worker had already completed, as well as the efficacy of the prior therapy to indicate additional sessions. In addition, the completed physical therapy should have been adequate to improve functionality and transition the injured worker to a home program where the injured worker may continue with exercises, such as strengthening, stretching, and range of motion. Therefore, the request for physical therapy quantity 8 left shoulder is non-certified.