

<b>Case Number:</b>	CM14-0150374		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	06/04/2010
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2014

### 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 American Board Internal Medicine 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:

The injured worker is a 57-year-old man who sustained a repetitive motion injury to the neck, upper extremities and bilateral shoulders in 2010. The mechanism of injury was not documented in the medical record. The IW has undergone an arthroscopic right shoulder rotator cuff repair in June 2010, a left shoulder rotator cuff repair/decompression in November 2011, and a right shoulder arthroscopic revision, decompression and distal clavicle excision on January 29, 2014. This was followed by twenty-four (24) sessions of post-operative physical therapy. The results of the therapy sessions were not documented in the medical record. A prior request for additional physical therapy on May 14, 2014 was non-certified. Pursuant to the progress note dated August 8, 2014 that was handwritten and largely illegible, the subjective complains were illegible. The provider documented range of motion flexion 150 degrees, abduction 150 degrees, adduction 36 degrees, internal rotation 85 degrees, and external rotation 57 degrees. The IW has pain above 120 degrees; muscle strength is 4/5 in all planes and a painful impingement sign. Diagnoses include: Status-post right shoulder scope, left elbow (?), the remaining 3 diagnoses were illegible in the medical record. Treatment plan includes a request for additional physical therapy 2 times a week for 4 weeks (8 sessions), continue home exercises, and refill for Norco 7.5/325mg 1 tablet orally every 12 hours as needed for pain #60. Of note, there is an Orthopedic Re-Examination Report dated May 29, 2014 that indicated that the IW was supposed to have therapy, but after 8 sessions he stopped because they were doing nothing for him. He describes some sort of passive treatment with electricity and hot packs.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy twice a week for four weeks:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder, Physical Therapy

**Decision rationale:** Pursuant to the Official Disability Guidelines, physical therapy twice a week for four weeks is not medically necessary. The Official Disability Guidelines enumerate the physical therapy allotment based on the specific condition. Rotator cuff syndrome/impingement syndrome, post-surgical treatment, arthroscopic allows 24 visits over 14 weeks. In this case, the injured worker underwent arthroscopic right shoulder rotator cuff repair in June 2010. Left shoulder rotator cuff repair/decompression in November 2011 and a right shoulder arthroscopic revision, decompression and distal clavicle excision in January 29, 2014. This was followed by 24 sessions of postoperative physical therapy. An orthopedic follow-up note May 29 of 2014 indicates 8 physical therapy sessions were provided to the injured worker. The injured worker stated the "PT did not help". The note reflects the injured worker was provided "some sort of passive treatment with electricity and hot packs". The injured worker received the maximum postsurgical arthroscopic physical therapy 24 visits. The follow progress note on September 10, 2014 was largely illegible as to indications for further physical therapy. The injured worker was on a home exercise program. There is no indication in the medical record indicating further functional improvement (due to illegibility). Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, physical therapy two times a week for four weeks is not medically necessary.

**Norco 7.5/325mg #60:** 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 Criteria for Ongoing Opiate Use. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Criteria for Ongoing Opiate Use

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Norco 7.5/325 mg #60 is not medically necessary. The guidelines states with ongoing narcotic use the medical record should contain an ongoing review of documentation of pain relief, functional status, appropriate medication use and side effects. The pain assessment include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opiate, how it takes for pain relief, and how long pain relief lasts. The satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improve quality of life. In this case, the injured worker has been taking Norco for a minimum of several months. The progress note dated May 15, 2014 indicates the injured worker was using Norco at that time. The medical record

documentation does not include the four A's for ongoing monitoring. This would include pain relief, side effects, physical and psychosocial functioning and the occurrence of any aberrant drug-related behaviors. The last progress note dated September 10, 2014 was largely illegible and did not contain any references to the ongoing management and review discussed above. Additionally, due to the illegibility of the physician progress notes there is no way to determine functional improvement (other than subjective improvement) associated with medication use. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, Norco 7.5/325#60 is not medically necessary.