

<b>Case Number:</b>	CM14-0159991		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	07/24/2012
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 33 year old with a work injury dated 7/24/12. The diagnoses include enthesopathy of wrist and carpus, carpal tunnel syndrome, unspecified site of elbow and forearm, and unspecified site of shoulder and upper arm; status post shoulder arthroscopy surgery done on April 10, 2014. Under consideration are requests for physical therapy, twice a week for six weeks to the right shoulder and Hydrocodeine 10/325 mg # 72. A recent progress report dated 09/07/14 is handwritten and somewhat illegible. It notes that the patient is feeling worse in the right shoulder. The patient reports moderate pain, stiffness and weakness in the bilateral shoulders. Physical examination reveals moderate tenderness, spasm and moderate pain with range of motion testing of the bilateral shoulders. There is a 09/08/14 progress note that indicates the patient has been undergoing physical therapy for the right shoulder postoperatively. The patient shows good progress with range of motion, but still has lack of full flexion, abduction and internal rotation, and weakness of the rotator muscle. The treatment plan was to complete the 24 visits per MTUS Postsurgical Treatment guidelines and also continue with a home exercise program. MRI that was done on July 28, 2014 showed that there is marked straightening of the cervical curvature with cervical myositis. There is no disc bulge or herniation noted.

### 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 six weeks to the right shoulder: 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 physical medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** Physical therapy, twice a week for six weeks to the right shoulder is not medically necessary per the MTUS Guidelines. The documentation is not clear on how many sessions of physical therapy the patient has already had. The guidelines recommend up to 24 sessions for this surgery. The guidelines recommend progression to an independent home exercise program. The documentation does not indicate specific objective evidence of improved function. The documentation indicates that the patient feels increased pain. Without evidence of functional improvement and without clarifications of how many prior PT sessions the patient has had the request for Physical therapy, twice a week for six weeks to the right shoulder is not medically necessary.

**Hydrocodeine 10/325 mg # 72:** 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 On-Going Management Page(s): 78-80.

**Decision rationale:** Hydrocodeine 10/325 mg # 72 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines do not recommend continuing opioids without evidence of functional improvement or improvement in pain. The documentation does not indicate evidence of significant functional improvement or pain on hydrocodeine therefore the request for hydrocodeine 10/325mg #72 is not medically necessary.