

<b>Case Number:</b>	CM14-0036086		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	01/08/2007
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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 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 case involves a male patient with the date of injury of January 8, 2007. A Progress Report dated March 5, 2014, identifies subjective complaints of pain in the left shoulder, more than in the right shoulder. The objective findings identify tenderness to (illegible) shoulder, improving range of motion, flexion at 145, abduction at 145, external rotation normal with pain, and internal rotation at 35. There is weakness to the muscles, acting upon the left shoulder at 4/5. The diagnoses identify rotator cuff rupture, arthropathy NOS-shoulder, and shoulder region disorder NEC (not elsewhere classified). The Treatment Plan identifies authorize physical therapy status post an arthroscopy with continued weakness and limited range of motion and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY TO THE LEFT SHOULDER TWO (2) TIMES A WEEK FOR SIX (6) WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10-12, and 27.

**Decision rationale:** The Postsurgical Treatment Guidelines recommend up to twenty-four (24) sessions of physical therapy after shoulder surgery, noting that an initial course of therapy consisting of half that amount may be prescribed and, with documentation of functional improvement, a subsequent course of therapy shall be prescribed. Within the documentation available for review, there is documentation of prior physical therapy sessions which have been completed. There are still remaining range of motion deficits and muscle weakness. However, there is no documentation of the number of prior physical therapy sessions completed. In addition, there is no mention of functional improvement with previous therapy. In the absence of such documentation, the request is not medically necessary.

**GABAPENTIN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-21.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that antiepilepsy drugs (AEDs) are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. The Guidelines also indicate that after the initiation of treatment, there should be documentation of pain relief and improvement in function, as well as documentation of side effects that incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of numeric rating scale (NRS)), no mention of neuropathic pain, and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding the side effects from this medication. In the absence of such documentation, the currently requested gabapentin is not medically necessary.

**HYDROCODONE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-79.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that Norco (hydrocodone) 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. The 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 hydrocodone is improving the patient's function or pain (in terms of percent reduction in pain or reduced numeric rating scale

(NRS)), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested hydrocodone is not medically necessary.