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| <b>Case Number:</b>   | CM15-0006582 |                              |            |
| <b>Date Assigned:</b> | 01/26/2015   | <b>Date of Injury:</b>       | 08/15/2011 |
| <b>Decision Date:</b> | 03/23/2015   | <b>UR Denial Date:</b>       | 12/18/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/12/2015 |

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 63-year-old female who reported an injury on 08/15/2011 due to an unspecified mechanism of injury. On 01/08/2015 she presented for a followup evaluation regarding her work related injuries. It was stated that she was seen for a right shoulder subacromial injection. Her preinjection level of pain was noted to be a 5/10. A physical examination showed that she was in no acute distress. She was provided with a right subacromial space steroid injection and tolerated the procedure well. She was diagnosed with right bicipital tendinitis and right shoulder strain. The treatment plan was for an additional office visit. The treatment plan requested was for tramadol 50 mg quantity 15 with 2 refills, and additional acupuncture twice weekly for the cervical spine and bilateral shoulders and left hip quantity of 12. The rationale for treatment was not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 50 MG Qty 15 with 2 Refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Managment Page(s): 78.

**Decision rationale:** According to the California MTUS Guidelines, an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the right shoulder. However, there is a lack of documentation regarding the injured worker's response to this medication in terms of a quantitative decrease in pain or an objective improvement in function. Also, official urine drug screens and CURES reports were not provided for review to validate that she has been compliant with her medication regimen. Also, 2 refills of the medication would not be supported without a re-evaluation to determine treatment success, and the frequency of the medication was not provided within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

**Additional Acupuncture Twice Weekly for The Cervical Spine, Bilateral Shoulders and Left Hip Qty 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** According to the California Acupuncture Guidelines, acupuncture is recommended at a frequency of 1 to 3 times per week for an optimum duration of 1 to 2 months. Based on the clinical documentation submitted for review, it would appear as though the injured worker has already been attending acupuncture therapy for an unspecified amount of sessions. Further clarification is needed regarding the number of sessions the injured worker has attended. Also, further information is needed regarding her response to treatment in terms of the quantitative decrease in pain and objective evidence of increased function. Therefore, the request is not supported. As such, the request is not medically necessary.