

Case Number:	CM15-0163601		
Date Assigned:	08/31/2015	Date of Injury:	06/24/2010
Decision Date:	10/07/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	08/20/2015

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: Pennsylvania, Ohio, California
 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 was a 25 year old female, who sustained an industrial injury, June 24, 2010. The injured worker previously received the following treatments right shoulder rotator cuff repair on March 20, 2011, Oxycodone, Tylenol, cervical spine MRI, 24 session of physical therapy for the right shoulder, TENS (transcutaneous electrical nerve stimulator) unit, failed Norco and Oxycodone. The injured worker was diagnosed with extremity pain, discogenic cervical, and impingement syndrome of the right shoulder, chronic pain and inactivity. According to progress note of August 3, 2015, the injured worker's chief complaint was head, neck, right shoulder, right arm, right elbow and right hand. The injured worker rated the pain at 8 out of 10. The injured workers quality of sleep was poor. The injured worker activity level had decreased. The physical exam note decreased range of motion of the right shoulder. There was tenderness with palpation of the acromioclavicular joint, biceps groove and coracoid process. The injured worker continued to have right upper extremity pain that was neuropathic in nature and affects the entire arm. The Oxycodone was discontinued and a trail of Tramadol was to start. The treatment plan included requests for Physical therapy for the right shoulder and prescriptions for Naproxen, Protonix, Tramadol ER and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 12 sessions 3 times per week for 4 weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.

Naproxen 550mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications.

Decision rationale: MTUS recommends NSAIDs as first-line treatment for chronic musculoskeletal pain. A prior physician review recommended non-certification due to lack of functional/vocational benefit and due to the complication of NSAID gastritis. However, MTUS does not require objective functional improvement to support ongoing NSAID use; documentation of subjective benefit is consistent with MTUS to support ongoing use, as is documentation of successful treatment of side effects, i.e. NSAID gastritis in this case. The risk vs. balance decision as documented in the records creates a reasonable basis for the treating physician to continue prescribing Naproxen. Therefore this request is medically necessary.

Protonix 20mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Protonix is indicated for gastrointestinal prophylaxis such as in patient with a history of NSAID gastritis. A prior physician review stated that protonix is not medically necessary because the underlying use of an NSAID was not medically necessary. As noted with

the request for Naproxen, the records document a reasonable risk/benefit analysis such that continuing NSAID use is reasonable and thus resuming Protonix for GI prophylaxis of ongoing NSAID use is reasonable. Thus the request overall is medically necessary.

Meds x 4 Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: MTUS discusses in detail the 4 As of opioid management, emphasizing the importance of dose titration vs. functional improvement and documentation of objective, verifiable functional benefit to support an indication for ongoing opioid use. The records in this case do not meet these 4As of opioid management and do not provide a rationale or diagnosis overall for which ongoing opioid use is supported. Therefore, this request is not medically necessary.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: MTUS discusses in detail the 4 As of opioid management, emphasizing the importance of dose titration vs. functional improvement and documentation of objective, verifiable functional benefit to support an indication for ongoing opioid use. The records in this case do not meet these 4As of opioid management and do not provide a rationale or diagnosis overall, for which ongoing opioid use is supported. Therefore, this request is not medically necessary.