

<b>Case Number:</b>	CM15-0217302		
<b>Date Assigned:</b>	11/09/2015	<b>Date of Injury:</b>	06/21/2012
<b>Decision Date:</b>	12/28/2015	<b>UR Denial Date:</b>	10/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2015

### 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, North Carolina Certification(s)/Specialty: Family Practice

### 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 50 year old female, who sustained an industrial injury on 6-21-12. Medical records indicate that the injured worker is undergoing treatment for cervical spine degenerative disc disease, intermittent right upper extremity radiculitis, right shoulder subacromial impingement and right shoulder partial thickness rotator cuff tear with status-post arthroscopic subacromial decompression. The injured worker is not currently working. On (10-1-15) the injured worker complained of increased right shoulder pain over the last week. Occasional popping and clicking of the right shoulder was noted. Objective findings revealed trace subacromial crepitation with passive and active motion. Forward flexion was 120, abduction 100, external rotation 70 and internal rotation 45. Strength was 5-5 in the bilateral upper extremities. Treatment and evaluation to date has included medications, MRI, electromyography-nerve conduction study, post-operative physical therapy, cervical injections, home exercise program and physical therapy and right shoulder surgery 12-17-14. Physical therapy notes were not provided for review. Current medications include Ibuprofen (since at least April of 2015). The treating physician noted that due to a recent flare-up of symptoms, a short course of physical therapy was recommended to reduce pain and swelling and improve function of the right shoulder. The Request for Authorization dated 10-21-15 included requests for physical therapy two times a week for four weeks to the right shoulder and ibuprofen 800mg #120 with one refill. The Utilization Review documentation dated 10-28-15 non-certified the requests for physical therapy two times a week for four weeks to the right shoulder and ibuprofen 800mg #120 with one refill.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 X 4 right shoulder:** Upheld

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

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

**Decision rationale:** The request is for additional physical therapy for the right shoulder. The claimant underwent a complete round of post-operative physical therapy to the right shoulder approximately 1 year ago. Physical therapy notes are not provided. There is no new injury to the shoulder noted, but a flare-up of symptoms recently. The patient has been prescribed a home exercise program (HEP), and no rationale is given as to why formal PT is necessary at this time versus HEP. Therefore the request is not medically necessary or appropriate at this time.

**Ibuprofen 800mg #120 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steriodal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk, NSAIDs (non-steriodal anti-inflammatory drugs).

**Decision rationale:** CA MTUS Guidelines support the use of NSAIDs like Ibuprofen for inflammatory conditions such as osteoarthritis. Ibuprofen is intended for use at the lowest dose for the shortest period of time. In this case the patient has been using Ibuprofen since April, 2015, and guidelines do not support long-term use. Long-term use of NSAIDs has been associated with GI and cardiovascular adverse effects. There appears to have been no effort to reduce the dose and/or frequency of the Ibuprofen. Therefore the request is not medically necessary or appropriate.