

<b>Case Number:</b>	CM14-0093973		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	10/19/2005
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	06/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 Orthopedic Surgery 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:

Patient is a 52-year-old female with date of injury of October 19, 2005. The patient has chronic right shoulder pain stiffness and weakness. She's had formal physical therapy which helped relieve her pain and improve her range of motion. She's had cortisone injections which provided relief for 2 days. Physical examination of the shoulder shows 160 of abduction with positive impingement and a painful range of motion. The patient is diagnosed with adhesive capsulitis of the shoulder. She had arthroscopic labral debridement and synovectomy on March 3, 2009. The patient continues to have shoulder pain. At issue is whether revision shoulder surgeries are medically necessary. The patient also has chronic neck pain. At issue is whether cervical MRI is medically necessary. Also at issue is whether multiple medications as needed for the patient's neck and shoulder condition.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed itemsSh

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder chapter

**Decision rationale:** The patient does not meet established criteria for revision shoulder decompressive surgery. The patient has been diagnosed with adhesive capsulitis. The clinical course of adhesive capsulitis is a self-limiting and conservative treatment including physical therapy and medications have good long-term treatment outcomes. The patient has shown some improvement with physical therapy already. Also, there is no clear documentation of an adequate recent trial and failure of aggressive physical therapy for adhesive capsulitis. The medical records do indicate that the patient had improvement with physical therapy. Revision decompressive shoulder procedure is not indicated at this time as the patient has mild symptoms with respect to range of motion loss and has shown some improvement with physical therapy to date. The criteria for revision surgery is not met, therefore, the request is not medically necessary.

**Norco 10/325mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids.

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

**Decision rationale:** Guidelines do not support the long-term use of narcotics for chronic pain. There is no clear documentation of functional improvement with previous narcotic therapy. In addition there is no documentation that the patient is about a functional restoration program. Guidelines do not support the use of narcotics for chronic pain. Additional narcotic therapy is not supported by the guidelines at this time. The request is not medically necessary.

**Ibuprofen 800 MG #90:** Upheld

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

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

**Decision rationale:** Evidence base guidelines to support the use of Motrin for osteoarthritis and mild to moderate pain. Higher doses are recommended for osteoarthritis but the daily dose should not exceed 3200 mg per day. Sufficient clinical improvement should be observed also potential risk of high-dose ibuprofen. High-dose ibuprofen is not medically appropriate at this time. Guidelines indicate that sufficient improvement should be observed also potential risk of high-dose treatment. The medical records do not report evidence of clinical improvement with previous Motrin treatment. High-dose Motrin is not supported by guidelines in this case, therefore, the request is not medically necessary.

**MRI Cervical Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back (Acute and Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter

**Decision rationale:** This patient does not meet established criteria for a cervical spine MRI. There is no documentation of neurologic findings in the upper extremity. There is no documentation of a trial and failure of conservative measures for neck pain recently. There is no documentation of significant neurologic deficit, fracture, or tumor. Since the criteria for cervical MRI has not been met, the request is not medically necessary.

### **1 Cervical Spine and Consultation and Treatment: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), neck pain chapter

**Decision rationale:** This patient does not meet established criteria for a referral for a cervical spine consultation and treatment. Specifically there is no documentation of her recent trial and failure of conservative measures for neck pain to include physical therapy. More conservative measures are needed for the treatment of neck pain prior to consultation. Since guidelines for a cervical spine consultation have not been met, the request is not medically necessary.