

Case Number:	CM15-0090856		
Date Assigned:	05/15/2015	Date of Injury:	09/01/2010
Decision Date:	06/16/2015	UR Denial Date:	04/15/2015
Priority:	Standard	Application Received:	05/11/2015

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: New Jersey, New York
 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 47 year old male, who sustained an industrial injury on 09/01/2010. He reported injuries to his left shoulder and ankle after being hit by a vehicle on his left side. The injured worker is currently temporarily totally disabled. The injured worker is currently diagnosed as having ankle strain, Achilles tendon sprain, shoulder strain, shoulder impingement, and frozen shoulder. Treatment and diagnostics to date has included left ankle surgery, physical therapy, acupuncture, rotator cuff repair, carpal tunnel release surgery, left shoulder MRI which showed partial thickness tear of rotator cuff, cognitive behavioral therapy, and medications. In a progress note dated 03/31/2015, the injured worker presented with complaints of constant pain in left shoulder and left ankle. The injured worker states pain is relieved by heat, medications, and ice and states his pain level is a 9-10 out of 10 and has extreme difficulty with all activities of daily living. Objective findings include back pain, joint stiffness and swelling, muscle spasms / cramps, and weakness. The treating physician reported requesting authorization for Oxycodone, physical therapy for the left shoulder, and physical therapy for the left ankle.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 40mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids, dosing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids, dosing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79, 86.

Decision rationale: The request for Oxycodone is not medically necessary. The patient has been on long-term opioid use. The chart does not provide any documentation of improvement in function with the use of Oxycodone. There are no documented recent urine drug screens or drug contracts, or long-term goals for treatment. The 4 As of ongoing monitoring were not adequately documented. The patient had continued pain and it was unclear what kind of relief Oxycodone provided. Because there was no documented evidence of objective functional gains with the use of Oxycodone, the long-term efficacy is limited, and there is high abuse potential, the risks of Oxycodone outweigh the benefits. The request is considered not medically necessary.

Physical Therapy for the left shoulder, QTY: 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The request for physical therapy for the left shoulder is not medically necessary. As per MTUS guidelines, post-rotator cuff treatment involves 24 visits over 14 weeks with a treatment period of 6 months. The patient had undergone physical therapy and it is unclear if had any improvement in function with these sessions. An additional 12 sessions that are being requested would exceed the recommended 24 visits. According to MTUS guidelines, a maximum of 10 sessions is recommended for myalgias/neuralgias. Twelve sessions would exceed this maximum. The patient should be proficient at a home exercise program at this point. Therefore, the request is considered not medically necessary.

Physical Therapy for the left ankle, QTY: 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for additional physical therapy is not medically necessary. As per the chart, the patient has already undergone physical therapy for his left ankle. There was no objective documentation of improvement in functional capacity from the previous physical therapy sessions. The request for additional 12 visits would exceed the 9-10 maximum amount of visits recommended for myalgias/neuralgias as per MTUS guidelines. At this point, the patient should be able to continue therapy with a home exercise program. Therefore, the request is considered not medically necessary.