

<b>Case Number:</b>	CM15-0097094		
<b>Date Assigned:</b>	05/27/2015	<b>Date of Injury:</b>	07/24/2014
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### 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

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 29 year old male, who sustained an industrial injury on 7/24/2014. He reported injury from falling from a ladder. The injured worker was diagnosed as having right chest wall contusion with right 7th rib fracture, facial contusions without fracture, concussion, tooth fracture, right shoulder rotator cuff tear, humerus head fracture and multiple soft tissue contusions and abrasions. There is no record of a recent diagnostic study. Treatment to date has included right shoulder arthroscopy, physical therapy and medication management. In a progress note dated 4/20/2015, the injured worker complains of increased vertigo, right shoulder pain with some improvement. Physical examination showed right bicep tenderness and increased right shoulder range of motion. The treating physician is requesting 8 acupuncture sessions for facial paralysis, 8 chiropractic care sessions for the cervical spine and vertigo, 12 additional physical therapy sessions for the right shoulder and Percocet 5/325 mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 acupuncture sessions for facial paralysis: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 8-9.

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

**Decision rationale:** For acupuncture, the MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial, and with functional improvement, 1 to 2 per month. For additional treatment, the MTUS Guidelines requires functional improvement as defined by Labor Code 9792.20(e) a significant improvement in ADLs, or change in work status and AND reduced dependence on medical treatments. In this case, the patient has been diagnosed with facial nerve paralysis. Progress reports do not document prior acupuncture for the face or its efficacy. While the patient may benefit from this treatment, MTUS recommends a 3 to 6 treatment trial and documentation of its impact on pain and function before further treatment. Hence, the request for 8 sessions is not medically necessary.

**8 chiropractic sessions for the cervical spine and vertigo:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8-9.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy Page(s): 58-59.

**Decision rationale:** MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/ flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. In this case, a request for chiropractic care is noted in progress report dated 04/20/15. Progress reports do not document prior chiropractic treatments or their efficacy. While the patient may benefit from this process, MTUS recommends a 6 treatment trial and documentation of its impact on pain and function before further treatment. Hence, the request for 8 visits is not medically necessary.

**12 additional physical therapy sessions for the right shoulder:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8-9.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 17-18.

**Decision rationale:** MTUS, post-surgical guidelines pages 17-18, recommend 24 visits over a period of 14 weeks for shoulder arthroscopy process. In this case, the patient is status post right shoulder arthroscopy on 01/14/15, and was within the post-operative time frame at the time of the request. The patient has already been authorized for 12 post-operative visits, as per the UR denial letter. In progress report dated, 05/18/15 after the UR date, the treater states that physical therapy helps increase strength and range of motion. MTUS also allows for 24 visits in post-operative cases. Hence, the treater's request for 12 additional sessions is medically necessary.

**Percocet 5/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8-9.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids Page(s): 76-78, 88-89.

**Decision rationale:** MTUS Guidelines pages 88 and 89 states, 'Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument.' MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as 'pain assessment' or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, a prescription for Percocet is first noted in progress report dated 09/29/14, and has been taking the medication consistently at least since then. UDS report, dated 03/16/15, was inconsistent for Percocet use, as the medication was not detected in urine. The treater does not use a numerical pain scale to demonstrate reduction in pain nor does the treater provide examples that indicate improvement in function. No CURES reports are available for review. MTUS guidelines require a clear discussion regarding the 4As, including analgesia, ADLs, adverse side effects, and aberrant behavior, for continued opioid use. Hence, this request is not medically necessary.