

<b>Case Number:</b>	CM14-0148931		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	09/13/2010
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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:

The injured worker is a 54-year-old female who reported an injury on 09/13/2010. The mechanism of injury was not stated. Current diagnoses include brachial neuritis or radiculitis, recurrent dislocation of the shoulder, and dislocation of the elbow. Previous conservative treatment is noted to include physical therapy, medication management, and multiple injections. The injured worker was evaluated on 08/06/2014 with complaints of persistent neck pain, bilateral shoulder pain, and right hand pain. It is noted that the injured worker completed a course of postoperative physical therapy for the right upper extremity. Physical examination revealed paravertebral muscle tenderness in the cervical spine, spasm, restricted range of motion, reduced sensation in the right ulnar nerve distribution, a well healed scar at the right wrist, and restricted range of motion of the right wrist. Treatment recommendations included continuation of the current medication regimen and physical therapy 3 times per week for 4 weeks for the neck and right upper extremity. A Request for Authorization Form was then submitted on 08/06/2014 for physical therapy, omeprazole 20 mg, orphenadrine ER 100 mg, Norco 5/325 mg, and Ambien 5 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 physical therapy sessions for RUE and Neck: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT).

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

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The injured worker has previously participated in physical therapy for the right upper extremity and cervical spine. However, there is no documentation of a significant functional limitation that would warrant the need for ongoing treatment. The injured worker has been instructed in a home exercise program. The medical necessity for the requested service has not been established. Therefore, the request is non-certified.

**Omeprazole DR 20 mg # 60 with two refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69..

**Decision rationale:** California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the medical necessity for the requested medication has not been established. As such, the request is not medically necessary.

**Orphenadrine ER 100 mg # 80 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66..

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. As per the documentation submitted, the injured worker has continuously utilized this medication since 03/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Hydrocodone 5/325 mg # 80 with two refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 74-82..

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the injured worker has utilized this medication since 03/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Ambien 5 mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain

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

**Decision rationale:** The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia or sleep disorder. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary.