

<b>Case Number:</b>	CM13-0065013		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	03/13/2012
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### 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 & Rehabilitation and is licensed to practice in Texas. 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 41-year-old female who reported an injury on 03/31/2012 when she was assisting a patient with ambulation reportedly caused injury to her low back, right shoulder and right knee. The injured worker's treatment history included physical therapy, chiropractic care, acupuncture, and multiple medications. The injured worker underwent a Functional Capacity Evaluation on 05/10/2013. Physical findings included restricted range of motion of the right shoulder described as 162 degrees in flexion, 48 degrees in extension, 128 degrees in abduction, 44 degrees in adduction, 90 degrees in external rotation and 70 degrees in internal rotation. Decreased grip strength on the right side, decreased pinch strength on the right side. The injured worker was evaluated on 10/08/2013. It was documented that the injured worker had continued limited range of motion secondary to pain, and diminished sensation along the L4 nerve root distribution of the left leg. It is documented that the injured worker had continued limited range of motion of the right shoulder. The injured worker's diagnoses included low back pain, radiculitis of the left lower extremity, degenerative disc disease, herniated disc of the lumbar spine, right shoulder tendinitis, right knee strain, tendinitis of the right shoulder, and impingement syndrome of the right shoulder. The injured worker's treatment plan included an additional Functional Capacity Evaluation, and continued medications to include cyclobenzaprine, diclofenac, omeprazole, ondansetron, and tramadol for pain relief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FUNCTIONAL CAPACITY EVALUATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The American College of Occupational and Environmental Medicine support Functional Capacity Evaluations when a more precise delineation of the injured worker's functional capabilities are required then what can be provided by a routine clinical examination. The clinical documentation submitted for review does indicate that the injured worker underwent a Functional Capacity Evaluation in 05/2013. However, there was no documentation of a significant change in the injured worker's clinical presentation that would alter the outcome of an additional Functional Capacity Evaluation. Therefore, the need for an additional Functional Capacity Evaluation is not supported. As such, the requested Functional Capacity Evaluation is not medically necessary or appropriate.

**CYCLOBENZAPRINE 7.5MG #30:** Upheld

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

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

**Decision rationale:** California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants in the management of chronic pain. The clinical documentation does indicate that the injured worker has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule does not support the use of muscle relaxants beyond a 2 to 3 week duration for acute exacerbations of chronic pain. There is no documentation that the injured worker is experiencing an acute exacerbation of chronic pain that would benefit from this medication. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested cyclobenzaprine 7.5 mg #30 is not medically necessary or appropriate.

**OMEPRAZOLE 20MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68.

**Decision rationale:** California Medical Treatment Utilization Schedule recommends that gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not

provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at significant risk for developing gastrointestinal related disturbances as a result of medication usage. Therefore, continued use of this medication would not be supported. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested omeprazole 20 mg #30 is not medically necessary or appropriate.

**ONDANSETRON 4MG #30: Upheld**

**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) PAIN CHAPTER, ANTI-EMETICS

**Decision rationale:** California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not recommend the treatment of nausea and vomiting related to chronic opioid usage. However, the Official Disability Guidelines do indicate that the use of this medication for acute gastritis would be appropriate. However, the clinical documentation submitted for review does not support the diagnosis of acute gastritis. Therefore, the use of this medication is not indicated. As such, the requested ondansetron 4 mg #30 is not medically necessary or appropriate.