

<b>Case Number:</b>	CM14-0102498		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	08/01/2002
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	07/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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 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:

The injured worker is a 53-year-old female who reported an injury on 08/01/2001. The mechanism of injury was not provided for clinical review. The diagnoses included bilateral upper extremity pain; impingement syndrome, bilateral, postoperative bilaterally; cubital tunnel and carpal tunnel syndrome; epicondylitis, lateral; supraspinator tunnel; and cervical spinal stenosis. Previous treatments included acupuncture, physical therapy, medication and injections. Surgeries included left shoulder arthroscopy in 2003, left carpal tunnel release in 2006, left supraspinator release in 2006. Diagnostic testing included Electromyography (EMG)/Nerve Conduction Velocity (NCV) and MRI. Within the clinical note dated 06/25/2014 it was reported the injured worker complained of intractable shoulder pain. She described the pain as sharp, throbbing and aching and the pain was constant. The injured worker complained of left hand/wrist pain and left elbow and forearm pain. Upon the physical examination the provider noted the injured worker was alert and oriented times 3. The request submitted is for a Functional Restoration Program, Anaprox DS twice a day. However, a rationale is not provided for clinical review. The Request for Authorization was submitted and dated on 01/02/2014. The injured worker is a 53-year-old female who reported an injury on 08/01/2001. The mechanism of injury was not provided for clinical review. The diagnoses included bilateral upper extremity pain; impingement syndrome, bilateral, postoperative bilaterally; cubital tunnel and carpal tunnel syndrome; epicondylitis, lateral; supraspinator tunnel; and cervical spinal stenosis. Previous treatments included acupuncture, physical therapy, medication and injections. Surgeries included left shoulder arthroscopy in 2003, left carpal tunnel release in 2006, left supraspinator release in 2006. Diagnostic testing included Electromyography (EMG)/Nerve Conduction Velocity (NCV) and MRI. Within the clinical note dated 06/25/2014 it was reported the injured worker complained of intractable shoulder pain. She described the pain as sharp, throbbing and

aching and the pain was constant. The injured worker complained of left hand/wrist pain and left elbow and forearm pain. Upon the physical examination the provider noted the injured worker was alert and oriented times 3. The request submitted is for a Functional Restoration Program, Anaprox DS twice a day. However, a rationale is not provided for clinical review. The Request for Authorization was submitted and dated on 01/02/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Functional Restoration Program:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration program Page(s): 30-32.

**Decision rationale:** The request for a Functional Restoration Program is not medically necessary. The California MTUS Guidelines provide 6 criteria for Functional Restoration Programs including an adequate and thorough evaluation has been made including baseline functional testing so that followup with the same test can note functional improvement. Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. The injured worker has a significant loss of ability to function independently resultant from chronic pain; she also is not a candidate where surgery or other treatments would clearly be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery for a trial of 10 visits may be implemented to assess whether surgery may be avoided. The injured worker exhibits motivation to change and is willing to forgo secondary gains including disability payments to affect this change. Negative predictor of success above has been addressed. Treatment is not suggested for more than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. There is lack of documentation indicating the injured worker underwent an adequate and thorough evaluation including baseline functional testing. There is lack of documentation indicating previous methods of treating chronic pain were unsuccessful and no documentation indicating she had significant loss of ability to function independently resulting from chronic pain. Additionally, the request submitted failed to provide the length of treatment the provider is requesting the injured worker to undergo. Therefore, the request is not medically necessary.

**Anaprox DS BID # 60 (MG Unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 66-67.

**Decision rationale:** The request for Anaprox ds bid #60 (mg unspecified) is not medically necessary. The California MTUS Guidelines note naproxen, also known as Anaprox, is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. The guidelines recommend NSAIDs at the lowest dose for the shortest period of time in patients with moderate to severe pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the dosage of the medication. Additionally, there is lack of documentation indicating the injured worker is treated for or diagnostic with osteoarthritis. Therefore, the request is not medically necessary.