

Case Number:	CM14-0167970		
Date Assigned:	10/15/2014	Date of Injury:	12/12/2013
Decision Date:	12/04/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/13/2014

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 Internal Medicine 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 (IW) is a 41-year-old woman with a date of injury of December 12, 2013. The mechanism of injury was not documented in the medical record. Pursuant to the progress note dated September 18, 2014 the IW complains of neck pain that radiates to the thoracic spine to bilateral arms and elbows. There is constant numbness and tingling in the palm of her hands, mostly thumbs, as well as weakness of the upper extremities and hands. She occasionally drops things. She reports frequent occipital to frontal headaches related to the cervical spine pain. She reports occasional severe dizziness. There is no blurred vision. She rates her pain at 5/10 at its worse, and 3/10 at its best. Objective findings include left shoulder is slightly higher, the head shifted slightly to the right. There is tenderness along the cervical spine, upper trapezium, paravertebral musculature, and positive cervical compression sign. There was decreased sensation in the bilateral upper extremities, tenderness in both shoulders, positive impingement sign, and tenderness at the medial and lateral epicondyle. Tinel's sign is positive at the right elbow, and pain with resisted dorsiflexion of the left wrist, evidence of carpal tunnel syndrome. Finkelstein's test is positive. There is tenderness along the lumbar spine, pain in the calf with heel walking, and pain in the right buttocks with full squatting. Straight leg raise test was positive. Mild positive left Baker's cyst and mild tenderness in the right forefoot. The IW has been diagnosed with cervical spine strain, rule-out radiculopathy; weakness in the right wrist and hand; thoracic spine strain; bilateral shoulder strain with impingement; lumbar spine strain with mild left sciatica; bilateral knee pain; and right elbow medial and lateral epicondylitis. The IW has a history of ulcers. Current medications include Ibuprofen 800mg, which caused aggravation of preexisting ulcer symptoms. Per the case notes, the IW had 12 sessions of physical therapy and 12 sessions of acupuncture. The provider is recommending a functional capacity evaluation,

Tramadol 50mg, Prilosec 20mg, Gabapentin/Ketoprofen/Lidocaine topical cream, and an interferential unit.

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 (ODG), Fitness for duty chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Functional Capacity Evaluation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7, pages 137-138

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, the functional capacity evaluation is not medically necessary. The guidelines state the examiner is responsible for determining whether the impairment results from functional limitations and to inform the examinee and the employer about the examinee's abilities and limitations. The physician should state whether the work restrictions are based on limited capacity, risk of harm or subjective examinee's intolerance for the activity in question. There is little scientific evidence confirming functional capacity evaluations predict an individual's actual capacity to perform in the workplace. For these reasons, it is problematic to rely solely upon functional capacity evaluations results for determination of current work abilities and restrictions. If a worker is actively participating in determining the suitability of the particular job, the functional capacity evaluation is more likely to be successful. Job specific functional capacity evaluations are more helpful than general assessments. Functional capacity evaluations are more helpful if there were prior unsuccessful return to work attempts close or at maximum medical improvement along with conflicting medical reporting on precautions and or fitness for a modified job. In this case, there was no documentation of prior unsuccessful return to work attempts nor does the worker have injuries that require a detailed exploration of work abilities. On April 1 of 2014 injured worker returned to modified work. Her diagnoses were bilateral shoulder trapezius strains; bilateral wrist flexor tenosynovitis; and bilateral carpal tunnel syndrome. Additionally, there were no conflicting medical reports regarding fitness for a modified job or special precautions. There is little scientific evidence confirming functional capacity evaluations predict an individual's actual capacity to perform in the workplace. It is problematic to rely solely upon functional capacity evaluations results for determination of current work abilities and restrictions. Consequently, a functional capacity evaluation is not medically necessary.

Interferential stimulation unit: Upheld

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

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, Interferential Stimulation Unit

Decision rationale: Pursuant to the Official Disability Guidelines, the Interferential current stimulation (ICS) unit is not medically necessary. ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise and medications. There is limited evidence of improvement on those recommended treatments alone. Patient selection criteria are available in the ODG. If the appropriate criteria are met then one month trial may be appropriate to permit the treating physician to determine whether there's evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this case, there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that evaluated the effectiveness of ICS have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and postoperative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues consequent ICS is not medically necessary.

Chiropractic treatment 3 x 4 to cervical/thoracic/lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

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, Neck, Back Physical Therapy

Decision rationale: Pursuant to the Official Disability Guidelines, chiropractic treatment three times a week for four weeks to the cervical/thoracic/lumbar region is not medically necessary. Physical therapy occupational therapy guidelines are provided in the Official Disability Guidelines section. It states allow for fading of treatment frequency (from up to three visits or more per week to one or less) plus active self-directed home PT. There must be functional objective improvement after the initial set of physical therapy. For carpal tunnel syndrome, medical treatment provides 1 to 3 visits over 3 to 5 weeks. Sprains and strains of the neck 10 visits over eight weeks. The ODG preface includes a six visit clinical trial. In this case, the diagnosis in the medical record is bilateral shoulder trapezius frames, bilateral wrist flexor tenosynovitis and bilateral carpal tunnel syndromes. The subjective complaints are bilateral wrist pain, bilateral hand tingling and numbness, bilateral shoulder pain with a negative review of systems. Objective findings bilateral shoulders show no swelling, no atrophy, tender over trapezius muscle spasm, range of motion, no instability, 5/5 rotator cuff strength, impingement sign negative, sulcus sign negative, speeds test is negative. The remainder of the examination was unremarkable. A review of the record shows the injured worker received 12 sessions of physical therapy and 12 sessions of acupuncture to date. The documentation in the medical record does not clearly state the indication for 12 sessions (three sessions per week for four

weeks) to the cervical/thoracic/lumbar region. Additionally, there are no lumbar (lower back) complaints noted in the medical record. Consequently, the documentation does not support physical therapy for the lumbar spine and the documentation doesn't support three sessions of physical therapy per week for four weeks to the cervical and thoracic regions. A six visit trial may be indicated. Based on clinical information in the medical record, the peer-reviewed evidence-based guidelines, physical therapy three times per week for four weeks to the cervical/thoracic/lumbar region is not medically necessary.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Prilosec Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Chapter, NSAID and GI Effects

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Prilosec 20 mg #60 is not medically necessary. Prilosec is a proton pump inhibitor. Proton pump inhibitors are indicated in patients that take nonsteroidal anti-inflammatory drugs with specific risk factors. The risk factors, include but are not limited to age greater than 65 years; history of peptic bleeding, G.I. bleeding, perforation; concurrent use of aspirin, steroids and/or anticoagulants; and high dose or multiple nonsteroidal anti-inflammatory drugs. In this case, the medical record is not contain any evidence of comorbid problems relating to the gastrointestinal tract. There is no history of peptic disease, G.I. bleeding, or multiple nonsteroidal anti-inflammatory drug use. Consequently, in the absence of comorbid conditions that warrant proton pump inhibitor use, Prilosec 20 mg #60 is not medically necessary.

Gaba/Keto/Lido cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Topical Analgesics

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Gabapentin/Ketoprofen/Lidocaine cream is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy and safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. In this case, Ketoprofen is not recommended by the FDA and is, therefore, not recommended. Topical Gabapentin is not recommended. Any compounded product that contains at least one drug (topical Gabapentin and

Ketoprofen) that is not recommended, is not recommended. Consequently, the topical compound containing Gabapentin/Ketoprofen/Lidocaine cream is not medically necessary.