

Case Number:	CM14-0045353		
Date Assigned:	08/06/2014	Date of Injury:	06/13/2013
Decision Date:	09/17/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	04/01/2014

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 65-year-old female who reported an injury on 06/13/2013 due to lifting. The injured worker's diagnoses were chronic sprain/strain of the cervical spine associated with radiated pain to the upper left extremity, cervical spine degenerative disc disease with disc herniation and spinal stenosis, chronic sprain/strain of the thoracic spine, chronic strain of the lumbar spine with associated radiated to the lower extremity, lumbar spine disc herniation and spinal stenosis at L4-5, contusions and sprain of the left shoulder, osteoarthritis of the left acromioclavicular joint, tendinosis of the left shoulder, sprain and strain of right shoulder, sprain and strain of the right knee, history of epigastric pain and H. pylori infection. The injured worker's prior treatments included acupuncture, physical therapy for the left shoulder, neck and low back, shockwave therapy and Functional Capacity Evaluation. Diagnostic studies included an endoscopy performed on 01/07/2014 which revealed some inflammation process of mild degree of the gastric fold and the antrum, but there were no ulcers, tumors or bleeding. The injured worker was also noted to have undergone an MRI of the cervical, lumbar and left shoulder. The injured worker complained of chronic neck and low back pain and also complained of epigastric pain. The injured worker indicated that the prescribed medications had been providing her with relief of symptoms. Other complaints include neck pain radiating to the arm with associated numbness of the arm, upper back pain worsened by sitting longer than 1 hour, low back pain radiating to the buttocks associated with numbness of the lower extremity and worsened by sitting longer than an hour, bilateral shoulder pain radiating to the arms worsened by lifting, left arm pain associated with numbness, left elbow pain worsened by lifting, left wrist, hand and finger numbness, bilateral leg pain associated with numbness, right knee pain and difficulty falling asleep. Examination on 05/19/2014 revealed tenderness to palpation of the cervical, thoracic and lumbar spine as well as to the left acromioclavicular joint, bicipital groove

and rotator muscles and the right shoulder. Range of motion of the cervical and lumbar spine was reduced. Straight leg raise was positive on the right at 60 degrees and positive on the left at 70 degrees. Apley's scratch test was positive on the left as well as Drop arm test. The provider's treatment plan was for conservative treatment consisting of medication, acupuncture treatments and home treatments. The injured worker's medications were omeprazole, Gaviscon 2 tsp after every meal, capsaicin cream 0.025% to be applied to affected body part twice daily and tramadol 50 mg every 8 hours for pain. The requested treatment plan is for Gaviscon, Prilosec, capsaicin, interferential unit, Mobic and Functional Capacity Evaluation. The rationale for the request was for the interferential unit was for in home use for pain symptoms of neck, low back, shoulder and knee pain. The rationale for the request of Prilosec, Gaviscon, capsaicin, Mobic and Functional Capacity Evaluation was not provided with documentation. The Request for Authorization form for Prilosec, Gaviscon, capsaicin, Mobic and Functional Capacity Evaluation dated 01/16/2014 was provided with documentation submitted for review, as well as Request for Authorization for the interferential unit which was dated 03/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gaviscon 240 ML #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Michigan Health System - Gastroesophageal Reflex Disease (GERD). Ann Arbor (MI): University of Michigan Health System: 2012 May. 12p (11 References).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs GI symptoms and cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation WebMD, Gaviscon.

Decision rationale: The California MTUS Chronic Pain Guidelines state recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. WebMD states the indications for Gaviscon include treating acid indigestion, heartburn, and sour stomach. The clinical information submitted indicated the injured worker had gastrointestinal problems and had a diagnosis of H. pylori infection; however, the documentation did not provide a specific diagnosis of gastroesophageal reflux or details regarding the injured worker's gastrointestinal symptoms to support the necessity of the requested medication. The documentation also failed to provide the efficacy of the medication to support continuation. The injured worker was also being prescribed Prilosec and there was a lack of rationale for providing the injured worker with medications that were both to address the injured worker's gastrointestinal symptoms. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Gaviscon 240 ML #1 is not medically necessary.

Prilosec 20mg #60: Upheld

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

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

Decision rationale: The California MTUS Chronic Pain Guidelines state that proton pump inhibitors may be recommended to treat dyspepsia secondary to NSAID therapy. The addition of a proton pump inhibitor is also supported for patients taking NSAIDs medications who have cardiovascular disease or significant risk factors for gastrointestinal events. The injured worker is noted to have diagnosis of H. Pylori infection and is noted to have gastrointestinal symptoms; however, the details of those symptoms were not provided. The documentation did not indicate the injured worker has cardiovascular disease or significant risk factors for gastrointestinal events. CA MTUS states recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Therefore, the necessity of the medication has not been established. The clinical information also fails to provide the efficacy of the medication to support continuation and the request as submitted fails to provide the frequency of the medication. Therefore, the request for Prilosec 20mg #60 is not medically necessary.

Capsaicin gel 0.025% 60gm #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesic Page(s): 28, 111.

Decision rationale: CA MTUS Guidelines state Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) Topical analgesics are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The clinical information submitted for review did not indicate the injured worker was intolerant or had not responded to other treatment to meet guideline indications for the requested medication. The clinical information provided failed to provide the efficacy of the medication to support continuation. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Capsaicin gel 0.025% 60gm #1 is not medically necessary.

Mobic 15mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 61, 67.

Decision rationale: CA MTUS Guidelines state meloxicam is a nonsteroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. It is recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. The clinical information provided indicated the injured worker had pain, tenderness to palpation and decreased range of motion. However, there was a lack of a diagnosis of osteoarthritis to support the necessity of the medication per guideline criteria. The efficacy of the medication was not provided to support continuation and the frequency was not provided in the request as submitted. Therefore, the request for Mobic 15mg #30 is not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG).

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

Decision rationale: CA MTUS/ACOEM guidelines state a Functional Capacity Evaluation is a supported tool in assessing for delayed recovery. Official Disability Guidelines state a Functional Capacity Evaluation is supported when case management is hampered by complex issues such as prior unsuccessful return to work attempts or the injured worker is close or at Maximum Medical Improvement/all key medical reports secured. However, it further states a Functional Capacity Evaluation should not be performed if the sole purpose is to determine a worker's effort or compliance or the injured worker has returned to work and an ergonomic assessment has not been arranged. The clinical information provided did not indicate the injured worker was close or at Maximum Medical Improvement or that prior unsuccessful return to work attempts have occurred. There was a lack of rationale for the requested evaluation. As such, the request for Functional Capacity Evaluation is not medically necessary.

IF 4 unit for home use: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: CA MTUS Guidelines state interferential current therapy 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, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. Criteria

includes pain is ineffectively controlled due to diminished effectiveness of medications or pain is ineffectively controlled with medications due to side effects or history of substance abuse or unresponsive to conservative measures. The clinical information provided did not document the injured worker's pain was ineffectively being controlled with the medications or other conservative measures to meet guideline criteria for the requested unit. The request does not specify whether it is a rental or purchase and the guidelines recommend a 30 day trial prior to a purchase which has not been documented. Therefore, the request for IF 4 unit for home use is not medically necessary.