

Case Number:	CM15-0018198		
Date Assigned:	02/06/2015	Date of Injury:	06/13/2013
Decision Date:	04/01/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/30/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials: State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 66 year old female, who sustained an industrial injury on 06/13/2013. She has reported subsequent neck and low back pain radiating to the bilateral upper and lower extremities and was diagnosed with chronic sprain/strain of the cervical, thoracic and lumbar spine, cervical degenerative disc disease with disc herniation, lumbar spine disc herniation and spinal stenosis, contusion and sprain of the left shoulder with osteoarthritis, carpal tunnel syndrome, right knee and shoulder sprain/strain, epigastric pain and H. pylori infection. Treatment to date has included oral pain medication, inferential unit, paraffin bath, physical, occupational and chiropractic therapy and acupuncture. In a progress note dated 08/25/2014, the injured worker complained of continued neck and low back pain radiating to the upper and lower extremities with bilateral wrist pain which had remained unchanged. Objective physical examination findings were notable for tenderness to palpation over the paracervical muscles, paradorsal thoracic muscles, paralumbar muscles, left rotator cuff muscles, bilateral wrists and right knee, as well as positive Tinel's and Finkelstein's tests, minimal spasm of the lumbosacral spine and pain with range of motion. Requests for authorization of functional capacity evaluation to assist in determining the baseline for the level of work conditioning activities, extracorporeal shockwave treatment of the shoulders for pain, Omeprazole and Gaviscon for gastric problems was made. On 12/30/2014, Utilization Review non-certified a request for 1 initial functional capacity evaluation between 8/25/2014 and 02/07/2015, noting that there was no evidence that the injured worker was close to reaching maximum medial improvement or that the condition included complex issues, non-certified a request for extracorporeal shockwave treatment to the shoulders, noting that the injured worker was not a candidate for this treatment, non-certified a request for Omeprazole, noting that there was no evidence of gastroesophageal reflux disease and non-certified a request for Gaviscon, noting that there were

no evidence based guidelines that supported the treatment of Helicobacter pylori with this medication. MTUS, ACOEM and ODG guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Initial Functional Capacity Evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines, Chapter 7, p137-139 has the following regarding functional capacity evaluations Official disability guidelines Low Back - Lumbar & Thoracic chapter, under Functional capacity evaluation (FCE).

Decision rationale: The patient is a 66 year old female who presents with unrated neck, upper back, lower back, bilateral shoulder, left arm/wrist/hand, and bilateral knee pain. Patient also complains of epigastric discomfort. The patient's date of injury is 06/13/13. Patient has no documented surgical history directed at these complaints. The request is for INITIAL FUNCTIONAL CAPACITY EVALUATION. The RFA was not provided. Physical examination dated 01/26/15 reveals tenderness over the thoracic and lumbar paraspinal muscles bilaterally, positive straight leg raise at 80 degrees. Shoulder examination reveals tenderness to palpation over the upper trapezius muscle, rotator cuff bilaterally, questionable drop arm test positive bilaterally, and reduced range of motion in all planes. Wrist examination reveals tenderness to palpation bilaterally at the carpal tunnel proper and "snuff box", positive Tinel's and Finklestein's tests bilaterally. Knee examination reveals tenderness to palpation over the entire joint, no loss in range of motion. The patient is currently prescribed Omeprazole and Mobic. Diagnostic imaging was not included, though progress note dated 01/26/15 describes multiple MRI's conducted on 07/13/13. C-Spine findings include: "C5 focal disc herniation with associated bilateral unconvertible joint degenerative disease changes which causes stenosis of the spinal canal and stenosis of the bilateral neuroal foramen that contact the bilateral C6 exiting nerve roots." Lumbar findings: "Disc herniation at L1-2 through L4-5, 2.5mm broad based posterior disc protrusion L4-L5." Shoulder findings: "Acromioclavicular joint osteoarthritis, Supraspinatus tendinosis, Infraspinatus tendinosis." Patient also has several stool samples positive for H. Pylori infection. Per 01/26/15 progress note patient is advised to return to work ASAP. Regarding functional capacity evaluation, ACOEM Guidelines Chapter page 137 states, "The examiner is responsible for determining whether the impairment results in functional limitations" The employer or claim administrator may request functional ability evaluations "These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial "There is no significant evidence to confirm that FCEs predict an individual's actual capacity to perform in a workplace." ODG Fitness For Duty, Low Back - Lumbar & Thoracic chapter, under Functional capacity evaluation (FCE)

states: "Recommended prior to admission to a Work Hardening Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally." ACOEM guidelines do not support FCE to predict an individual's work capacity. ACOEM supports FCE if asked by the administrator, employer, or if it is deemed crucial. In regards to the request for a functional capacity evaluation, the treater has not specified a reason for the request. Functional capacity evaluations are recommended by ODG guidelines as a prerequisite to work hardening programs designed to return a patient to the workforce, though there is no indication that this patient intends on returning to the workforce. Progress note dated 01/26/15 instructs the patient to return to work ASAP though does not specify a reason to perform the FCE. Therefore, this request IS NOT medically necessary.

Unknown Extracorporeal Shockwave Treatment To The Shoulders: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, under Extracorporeal Shockwave Treatment - ESWT.

Decision rationale: The patient is a 66 year old female who presents with unrated neck, upper back, lower back, bilateral shoulder, left arm/wrist/hand, and bilateral knee pain. Patient also complains of epigastric discomfort. The patient's date of injury is 06/13/13. Patient has no documented surgical history directed at these complaints. The request is for UNKNOWN EXTRACORPOREAL SHOCKWAVE TREATMENT TO SHOULDERS. The RFA was not provided. Physical examination dated 01/26/15 reveals tenderness over the thoracic and lumbar paraspinal muscles bilaterally, positive straight leg raise at 80 degrees. Shoulder examination reveals tenderness to palpation over the upper trapezius muscle, rotator cuff bilaterally, questionable drop arm test positive bilaterally, and reduced range of motion in all planes. Wrist examination reveals tenderness to palpation bilaterally at the carpal tunnel proper and "snuff box", positive Tinel's and Finklestein's tests bilaterally. Knee examination reveals tenderness to palpation over the entire joint, no loss in range of motion. The patient is currently prescribed Omeprazole and Mobic. Diagnostic imaging was not included, though progress note dated 01/26/15 describes multiple MRI's conducted on 07/13/13. C-Spine findings include: "C5 focal disc herniation with associated bilateral unconvertible joint degenerative disease changes which causes stenosis of the spinal canal and stenosis of the bilateral neuroforamina that contact the bilateral C6 exiting nerve roots." Lumbar findings: "Disc herniation at L1-2 through L4-5 2.5mm broad based posterior disc protrusion L4-L5." Shoulder findings: "Acromioclavicular joint osteoarthritis, Supraspinatus tendinosis, Infraspinatus tendinosis." Patient also has several stool samples positive for H. Pylori infection. Per 01/26/15 progress note patient is advised to return to work ASAP. ODG Guidelines, Shoulder Chapter, under Extracorporeal Shockwave Treatment - ESWT - states, "Recommended for calcifying tendinitis, but not for other disorders, for patients with calcifying tendinitis of the shoulder in homogeneous deposits, quality evidence have found extracorporeal shock wave therapy equivalent or better than surgery and it may be given priority because of its non-invasiveness." The medical file provided for review includes an MRI of the

right shoulder dated 07/13/13, its findings include; Acromioclavicular joint osteoarthritis, Supraspinatus tendinosis, and infraspinatus tendinosis - no findings mentioning calcium deposits. There is no documentation of prior shockwave therapy, however the MRI findings do not demonstrate calcium deposits on tendon or calcified tendinitis for which ESWT is considered appropriate. Therefore, the request IS NOT medically necessary.

60 Omeprazole 20 MG: Overturned

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): 69.

Decision rationale: The patient is a 66 year old female who presents with unrated neck, upper back, lower back, bilateral shoulder, left arm/wrist/hand, and bilateral knee pain. Patient also complains of epigastric discomfort. The patient's date of injury is 06/13/13. Patient has no documented surgical history directed at these complaints. The request is for 60 OMEPRAZOLE 20MG. The RFA was not provided. Physical examination dated 01/26/15 reveals tenderness over the thoracic and lumbar paraspinal muscles bilaterally, positive straight leg raise at 80 degrees. Shoulder examination reveals tenderness to palpation over the upper trapezius muscle, rotator cuff bilaterally, questionable drop arm test positive bilaterally, and reduced range of motion in all planes. Wrist examination reveals tenderness to palpation bilaterally at the carpal tunnel proper and "snuff box", positive Tinel's and Finklestein's tests bilaterally. Knee examination reveals tenderness to palpation over the entire joint, no loss in range of motion. The patient is currently prescribed Omeprazole and Mobic. Diagnostic imaging was not included, though progress note dated 01/26/15 describes multiple MRI's conducted on 07/13/13. C-Spine findings include: "C5 focal disc herniation with associated bilateral unconvertible joint degenerative disease changes which causes stenosis of the spinal canal and stenosis of the bilateral neuroal foramen that contact the bilateral C6 exiting nerve roots." Lumbar findings: "Disc herniation at L1-2 through L4-5, 2.5mm broad based posterior disc protrusion L4-L5." Shoulder findings: "Acromioclavicular joint osteoarthritis, Supraspinatus tendinosis, Infraspinatus tendinosis." Patient also has several stool samples positive for H. Pylori infection. Per 01/26/15 progress not patient is advised to return to work ASAP. MTUS Chronic Pain Medical Treatment Guidelines pg. 69 states "NSAIDs - Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI, PPI's are also allowed for prophylactic use along with NSAIDS, with proper GI assessment, such as age greater than 65, concurrent use of oral anticoagulants, ASA, high dose of NSAIDs, or history of peptic ulcer disease, etc."In regards to the request for a continuation of this patient's Omeprazole, the request appears reasonable. Progress reports indicate that this patient has been receiving Omeprazole since at least 08/25/14. Subsequent reports consistently mention this patient's epigastric pain. Furthermore, this patient has tested positive and has been treated in the past for H. Pylori infection. Additionally, this patient is currently taking an NSAID, Mobic. Given this patient's GI complaints, medication profile, and history of H. Pylori infection, a PPI such as Omeprasole is an appropriate treatment. The request IS medically necessary.

1 Prescription of Gaviscon: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Family Physician Practice Guidelines for Diagnosis and Treatment of Gerd.

Decision rationale: The patient is a 66 year old female who presents with unrated neck, upper back, lower back, bilateral shoulder, left arm/wrist/hand, and bilateral knee pain. Patient also complains of epigastric discomfort. The patient's date of injury is 06/13/13. Patient has no documented surgical history directed at these complaints. The request is for 1 PRESCRIPTION OF GAVISCON. The RFA was not provided. Physical examination dated 01/26/15 reveals tenderness over the thoracic and lumbar paraspinal muscles bilaterally, positive straight leg raise at 80 degrees. Shoulder examination reveals tenderness to palpation over the upper trapezius muscle, rotator cuff bilaterally, questionable drop arm test positive bilaterally, and reduced range of motion in all planes. Wrist examination reveals tenderness to palpation bilaterally at the carpal tunnel proper and "snuff box", positive Tinel's and Finklestein's tests bilaterally. Knee examination reveals tenderness to palpation over the entire joint, no loss in range of motion. The patient is currently prescribed Omeprazole and Mobic. Diagnostic imaging was not included, though progress note dated 01/26/15 describes multiple MRI's conducted on 07/13/13. C-Spine findings include: "C5 focal disc herniation with associated bilateral unconvertible joint degenerative disease changes which causes stenosis of the spinal canal and stenosis of the bilateral neuroal foramen that contact the bilateral C6 exiting nerve roots." Lumbar findings: "Disc herniation at L1-2 through L4-5, 2.5mm broad based posterior disc protrusion L4-L5." Shoulder findings: "Acromioclavicular joint osteoarthritis, Supraspinatus tendinosis, Infraspinatus tendinosis." Patient also has several stool samples positive for H. Pylori infection. Per 01/26/15 progress note patient is advised to return to work ASAP. ODG and MTUS guidelines do not specifically address the use of antacids - such as Gaviscon - American Family Physician Practice Guidelines for Diagnosis and Treatment of Gerd States: "Acid suppression is the basis of treatment for GERD, and can be accomplished most quickly and effectively with PPIs. In 33 randomized trials that included more than 3,000 patients with erosive esophagitis, more patients experienced symptom relief and healing of esophagitis with PPI therapy than with H2RA therapy. Even when higher and more frequent doses of H2RAs are used, the improvement rates do not match those of PPIs. Long-term PPI therapy is extremely beneficial in patients with chronic or complicated GERD, and safety concerns are minor. Higher-than-approved dosages of PPIs may be appropriate in certain situations, such as in patients who show only a partial response to standard doses or are having breakthrough symptoms, in empiric treatment trials for supraesophageal GERD symptoms, and in cases of severe esophageal dysmotility or Barrett's esophagus. The dose should be divided and the second dose given before the evening meal, not at bedtime." In regards to the request for Gaviscon, an over the counter antacid medication, treater has not provided a rationale as to why current PPI therapy is inadequate. While this patient presents with significant gastric history, continuing epigastric complaints, though AFP guidelines indicate that a more appropriate avenue would be to increase the dose of PPI to achieve maximum benefit. The requested antacid has no peer reviewed support. Therefore, the request IS NOT medically necessary.