

Case Number:	CM15-0194500		
Date Assigned:	10/08/2015	Date of Injury:	01/16/1996
Decision Date:	11/16/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	10/02/2015

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 62 year old female, who sustained an industrial injury on January 16, 1996. The injured worker was diagnosed as having status post right ring finger trigger finger release and right de Quervain's tenosynovitis. Treatment and diagnostic studies to date have included the above noted procedure and medication regimen. In a progress note dated August 24, 2015 the treating physician reports complaints of recent chest pain that radiated to the left upper extremity and indicated that the injured worker's internist ruled out cardiac issues and noted that the symptoms improved with Toradol, but did not indicate the injured worker's pain level prior to Toradol and after Toradol to determine the effects of the Toradol. Examination performed on August 24, 2015 was revealing for positive Phalen's testing to the left wrist, positive median nerve compression testing, positive Finkelstein's testing to the right wrist, tenderness to the right first dorsal compartment, and decreased range of motion to the bilateral wrists. The progress note from August 24, 2015 did not indicate the injured worker's current medication regimen, but the medical records provided noted prior prescriptions of the medications of Omeprazole and Diclofenac XR since at least June of 2015. The progress note from August 24, 2015 did not include any gastrointestinal symptoms during this visit. On August 24, 2015 the treating physician requested functional capacity evaluation to determine her true work restrictions and impairment rating based on her evaluation. The treating physician also requested the medication of Omeprazole 20mg with a quantity of 60 for gastritis prophylaxis along with noting prior prescriptions of medication of Diclofenac XR. On September 02, 2015, the Utilization Review determined the requests for one functional capacity evaluation and Omeprazole 20mg with a quantity of 60 to be non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

One 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: Functional Capacity Evaluation (FCE) 2015.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures.

Decision rationale: Though functional capacity evaluations (FCEs) are widely used and promoted, it is important for physicians and others to understand the limitations and pitfalls of these evaluations. Functional capacity evaluations may establish physical abilities, and also facilitate the examinee/employer relationship for return to work. However, FCEs can be deliberately simplified evaluations based on multiple assumptions and subjective factors, which are not always apparent to their requesting physician. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities. As with any behavior, an individual's performance on an FCE is probably influenced by multiple non-medical factors other than physical impairments. For these reasons, it is problematic to rely solely upon the FCE results for determination of current work capability and restrictions. It is the employer's responsibility to identify and determine whether reasonable accommodations are possible to allow the examinee to perform the essential job activities. The patient has received a significant amount of conservative treatments without sustained long-term benefit. The patient continues to treat for ongoing significant symptoms with further plan for care without noted work status change. It appears the patient continues to treat for chronic pain symptoms. Current review of the submitted medical reports has not adequately demonstrated the indication to support for the request for Functional Capacity Evaluation as the patient continues to actively treat. Per the ACOEM Treatment Guidelines on the Chapter for Independent Medical Examinations and Consultations regarding Functional Capacity Evaluation, there is little scientific evidence confirming FCEs ability to predict an individual's actual work capacity as behaviors and performances are influenced by multiple nonmedical factors which would not determine the true indicators of the individual's capability or restrictions. The One functional capacity evaluation is not medically necessary and appropriate.

Omeprazole 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Proton pump inhibitor (PPI) medication is for treatment of the problems associated with active gastric ulcers, erosive esophagitis, Barrett's esophagitis, or in patients with pathologic hypersecretion diseases. Although preventive treatment is effective for the mentioned diagnosis, studies suggest; however, nearly half of PPI prescriptions are used for unapproved or

no indications. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for PPI namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Long term use of PPIs have potential increased risks of B12 deficiency; iron deficiency; hypomagnesemia; susceptibility to pneumonia, enteric infections, fractures, hypergastrinemia and cancer, and cardiovascular effects of myocardial infarction (MI). In the elderly, studies have demonstrated increased risk for Clostridium difficile infection, bone loss, and fractures from long-term use of PPIs. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any identified history of acute GI bleeding, active ulcers, or confirmed specific GI diagnosis criteria to warrant this medication. The Omeprazole 20mg, #60 is not medically necessary and appropriate.