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| Case Number: | CM14-0073345 | | |
| Date Assigned: | 07/16/2014 | Date of Injury: | 02/01/2012 |
| Decision Date: | 06/08/2015 | UR Denial Date: | 04/26/2014 |
| Priority: | Standard | Application Received: | 05/20/2014 |

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. 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, Hawaii
 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 45 year old male, who sustained an industrial injury on 02/01/2012. The initial complaints or symptoms included left shoulder, right wrist, back, neck, and face pain/injury as the result of a 20-foot fall. The injured worker was diagnosed as having left shoulder fracture/injury, right wrist fracture, and broken bridgework (dental). Treatment to date has included conservative care, medications, x-rays, MRIs, CT scans, right wrist surgery, electrodiagnostic testing, psychological therapy, conservative therapies, sleep study, and oral surgery. Currently, the injured worker complains of pain and weakness in the right hand and wrist. Several documents within the submitted medical records are difficult to decipher. The diagnoses include other closed fractures of distal end of radius (alone), closed fracture of unspecified part of humerus, other affections of shoulder region, not elsewhere classified, sleep disturbance, and unspecified functional disorder of stomach. The request for authorization included a final functional capacity evaluation, oral naproxen, and naproxen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Final 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines page 137.

Decision rationale: The patient presents with pain affecting the right hand and wrist. The current request is for Final Functional Capacity Evaluation. The treating physician report dated 6/19/14 (108) states, "Functional Capacity Evaluation for Primary Treating physician's Permanent and Stationary Report (PR-4): It is needed to determine if an employee is able to resume working in a capacity commensurate with his or her skills or abilities." Regarding Functional/Capacity Evaluation, ACOEM Guidelines 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 little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace." In this case, there is no evidence showing that the FCE was requested by the employer or the claims administrator. Furthermore, there is no evidence in the documents provided that suggests the patient has a desire to return to work and is unable to do so because of functional limitations. The treating physician has not documented that the requested FCE is crucial in any way. The ACOEM guidelines require much more documentation to recommend a functional capacity evaluation. The request is not medically necessary; recommendation is for denial.

Naproxen cream 240gm #1 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The patient presents with pain affecting the right hand and wrist. The current request is for Naproxen cream 240gm #1 with 1 refill. The treating physician report dated 6/19/15 (106) states, "He reports occasional pain on the palmar aspect of the right hand rated 3 to 5/10. The pain radiates to the middle ring fingers." The report also goes on to note that the patient has a severe change in his ability to write, type, and grasp objects, due to severe pain in his right hand and wrist. The MTUS guidelines state that topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment analgesics. The patient is currently being prescribed an Oral NSAID in the form of Naprosyn and suffers from Gastritis. In this case, while the treating physician has documented that the patient is suffering from continued wrist and hand pain, and gastritis, there is no documentation that the patient has received any functional improvement from the use of Naproxen cream in the past as required in MTUS page 60. Furthermore, the request for 1 refill without documentation of functional improvement is not supported. The request is not medically necessary; recommendation is for denial.

