

Case Number:	CM15-0010407		
Date Assigned:	01/28/2015	Date of Injury:	10/29/2012
Decision Date:	03/20/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/19/2015

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: New York
 Certification(s)/Specialty: Emergency Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 49 year-old female who has reported neck, back, and shoulder pain after an injury on October 19, 2012. The diagnoses have included cervical strain, frozen left shoulder, thoracic and lumbar strain, and tendinitis. Treatment has included shoulder decompression surgery in May 2014, physical therapy, a chronic pain consultation, and medications. Per the report of 7/2/14, the injured worker is in the post-operative period, is prescribed diclofenac and omeprazole, and will need a functional capacity evaluation to determine an impairment rating. Work status was modified. Subsequent reports show gradual improvement and a return to full duty on 9/17/14. The same medications were given chronically with no discussion of the specific results of using them. The functional capacity evaluation was routinely listed in each report. A pain management consultation was prescribed on 10/22/14. Subsequent reports refer to ongoing pain management in-house with no details given. As of 11/26/14 the injured worker was improved. Pain management was ongoing. Unspecified medications reportedly provided unspecified improvement in function, pain, and gastritis. Omeprazole was given for gastritis prophylaxis and Diclofenac for inflammation. On December 22, 2014, the Utilization Review non-certified a functional capacity assessment, a chronic pain management follow-up, Diclofenac 100mg #60 and Omeprazole 20mg #60. The MTUS and the Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac 100mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain NSAIDs for Back Pain - Acute exacerbations of chronic pain Back. Decision based on Non-MTUS Citation Pain chapter, Diclofenac

Decision rationale: Per the MTUS for chronic pain, page 60, medications should be trialed one at a time, and there should be functional improvement with each medication. No reports show any specific benefit of diclofenac. Diclofenac has been prescribed for months, at minimum, with no description of the specific results of use. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. Diclofenac, per the Official Disability Guidelines citation and other medical evidence, has one of the highest risk profiles of all the NSAIDs. It should not be the NSAID of first choice, yet this there is no apparent consideration of this fact by the treating physician and no monitoring of the inherent risks. And the treating physician is reporting gastritis, yet continues to prescribe diclofenac. In addition, the request does not include dosing frequency or duration. For these reasons, ongoing use of diclofenac is not medically necessary.

Omeprazole 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, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: There are no medical reports which adequately describe the relevant signs and symptoms of possible gastrointestinal disease. There is no examination of the abdomen on record. The treating physician has referred to the presence of gastritis but without any clinical findings or history. There are many possible etiologies for gastrointestinal symptoms; the available reports do not provide adequate consideration of these possibilities. Empiric treatment after minimal evaluation is not indicated. The treating physician may be referring to some sort of gastrointestinal symptoms while taking NSAIDs. If so, the NSAID is not indicated as discussed above. If one were to presume that a medication were to be the cause of the gastrointestinal symptoms, the treating physician would be expected to change the medication regime accordingly, at least on a trial basis to help determine causation. Note the MTUS recommendation regarding the options for NSAID-induced dyspepsia. In this case, there is no evidence of any attempts to determine the cause of symptoms, including minimal attempts to adjust medications. The MTUS, FDA, and recent medical literature have described a significantly increased risk of hip, wrist, and spine fractures; pneumonia, Clostridium-difficile-associated diarrhea, and hypomagnesemia in patients on proton pump inhibitors. In addition, the

request does not include dosing frequency or duration. Omeprazole is not medically necessary based on lack of medical necessity and risk of toxicity.

Chronic Pain Management Follow Up: 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)-TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

Decision rationale: The MTUS does not provide references to pain management. The MTUS does make general references to this kind of care (PMR referral when surgery is not indicated), in the reference cited above. In this case, the treating physician has provided no specific indications for pain management. The primary treating physician continues to treat whatever pain there is to date with no references to any treatment provided by his in-house consultant. There are no reports from that consultant. The content of that care is not stated in the records. The reasons for ongoing care by this other physician are not stated. The presence of chronic pain itself does not imply medical necessity for multiple physicians to treat the patient. The treating physician placed no parameters such as duration of treatment or frequency of visits on this pain management. For these reasons, a non-specific pain management follow-up is not medically necessary.

Functional Capacity Assessment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Fitness for Duty Procedure Summary

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81. Decision based on Non-MTUS Citation Fitness for Duty chapter, Functional capacity evaluation. Chapter 7, discussion of IME recommendations (includes functional capacity evaluation).

Decision rationale: The treating physician has been repeating a future need for a functional capacity evaluation for months. The only stated purpose is that of impairment rating. If that is the only purpose, it is not a question of medical treatment necessity but one of rating impairment alone, which is not a subject for Independent Medical Review. If there were to be another purpose for the request, the treating physician has not provided an adequate basis for the request. The ACOEM guidelines pages 137-8, in the section referring to Independent Medical Evaluations (which is not the context in this case), states there is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace and it is problematic to rely solely upon the functional capacity evaluation results for determination of current work capability and restrictions. The MTUS for Chronic Pain and the Official Disability Guidelines recommend a functional capacity evaluation for Work

Hardening programs, which is not the context in this case. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation (assuming that any exists), cannot be determined without a specific prescription which includes a description of the intended content of the evaluation. The MTUS for Chronic Pain, in the Work Conditioning-Work Hardening section, mentions a functional capacity evaluation as a possible criterion for entry, based on specific job demands. The treating physician has not provided any information in compliance with this portion of the MTUS. The injured worker has apparently returned to usual work, which renders the question of a functional capacity evaluation moot. The functional capacity evaluation in this case is not medically necessary based on lack of medical necessity and lack of a sufficiently specific prescription.