

Case Number:	CM15-0127501		
Date Assigned:	07/14/2015	Date of Injury:	05/02/2014
Decision Date:	09/18/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/01/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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:

The injured worker is a 43-year-old male who sustained an industrial /work injury on 5/2/14. He reported an initial complaint of pain in right wrist, forearm, and elbow. The injured worker was diagnosed as having right elbow sprain/strain, right/left elbow medial epicondylitis, and bilateral upper extremity myofascial pain. Treatment to date includes medication. Currently, the injured worker complained of constant sharp pain over the right elbow, forearm, and hand region with numbness and tingling in his 1st, 2nd, and 3rd digits that interrupts sleep. There was also pain in the right elbow on the medial aspect. Per the primary physician's report (PR-2) on 5/5/15, exam revealed tenderness along the joint line, the elbow revealed tenderness over the medial epicondyle region, tenderness over the left forearm with note of carpal tunnel syndrome. Current plan of care included wrist brace, elbow brace, electric heat pad, and Functional Capacity Evaluation (FCE), and therapy sessions. The requested treatments include Omeprazole BID, transcutaneous electrical nerve stimulation (TENS) unit, Physical therapy; 8-10 sessions, upper extremity, FCE (functional capacity evaluation), and Elbow brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole BID #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, cardiovascular risks.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: MTUS and ODG states, "Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e. g. , NSAID + low-dose ASA)." And "Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1. 44)." The medical documents provided do not establish the patient has having documented GI bleeding, perforation, peptic ulcer, high dose NSAID, or other GI risk factors as outlined in MTUS. As such, the request for Omeprazole BID #60 is not medically necessary.

TENS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation).

Decision rationale: MTUS states regarding TENS unit, "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below". For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention. Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program. Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings. Ankle and foot: Not recommended. Elbow: Not recommended. Forearm, Wrist and Hand: Not recommended. Shoulder: Recommended for post-stroke rehabilitation. Medical records do not indicate conditions of the low back, knee, neck, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis. As such, the request for TENS is not medically necessary.

Physical therapy; 8-10 sessions, upper extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute & Chronic), Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine". Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted". ODG further quantifies physical therapy for the elbow with: ODG Physical Therapy Guidelines: General: Up to 3 visits contingent on objective improvement documented (i. e. vas improvement of greater than 4). Further trial visits with fading frequency up to 6 contingent on further objectification of long term resolution of symptoms, plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface. Sprains and strains of elbow and forearm (ICD9 841): Medical treatment: 9 visits over 8 weeks. Post-surgical treatment/ligament repair: 24 visits over 16 weeks. Lateral epicondylitis/Tennis elbow (ICD9 726. 32): Medical treatment: 8 visits over 5 weeks. Post-surgical treatment: 12 visits over 12 weeks. Medial epicondylitis/Golfers' elbow (ICD9 726. 31): Medical treatment: 8 visits over 5 weeks. Post-surgical treatment: 12 visits over 12 weeks. Enthesopathy of elbow region (ICD9 726. 3): Medical treatment: 8 visits over 5 weeks. Post-surgical treatment: 12 visits over 12 weeks. Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354. 2): Medical treatment: 14 visits over 6 weeks. Post-surgical treatment: 20 visits over 10 weeks. Olecranon bursitis (ICD9 726. 33): Medical treatment: 8 visits over 4 weeks. Dislocation of elbow (ICD9 832): Stable dislocation: 6 visits over 2 weeks. Unstable dislocation, post-surgical treatment: 10 visits over 9 weeks. Fracture of radius/ulna (ICD9 813): Post-surgical treatment: 16 visits over 8 weeks. Fracture of humerus (ICD9 812): Medical treatment: 18 visits over 12 weeks. Post-surgical treatment: 24 visits over 14 weeks. Ill-defined fractures of upper limb (ICD9 818): 8 visits over 10 weeks. Arthropathy, unspecified (ICD9 716. 9): Post-surgical treatment, arthroplasty, elbow: 24 visits over 8 weeks. Rupture of biceps tendon (ICD9 727. 62): Post-surgical treatment: 24 visits over 16 weeks. The medical documentation indicate that this patient has previously attended approximately 6 physical therapy sessions, however, it appears that therapy was completed over 1 year ago and it is unclear if this patient obtained functional improvement with this therapy. Guidelines recommend a 6 visit clinical trial to evaluate efficacy of physical therapy. The requested number of sessions is in excess of guideline recommendations. The treating physician does not explain the extenuating circumstances to allow for an exception to the guidelines. As such, the request for Physical therapy; 8-10 sessions, upper extremity is not medically necessary as presented.

FCE (functional capacity evaluation): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7: Independent Medical Examinations and Consultations Official Disability Guidelines (ODG), fitness for duty chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE).

Decision rationale: ACOEM guidelines state "Consider using a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability". Additionally, "It may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient". ODG further specifies guidelines for functional capacity evaluations "Recommended prior to admission to a Work Hardening (WH) Program." "An FCE is time-consuming and cannot be recommended as a routine evaluation". "Consider an FCE if 1. Case management is hampered by complex issues such as: "Prior unsuccessful RTW attempts." Conflicting medical reporting on precautions and/or fitness for modified job. "Injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate: "Close or at MMI/all key medical reports secured". Additional/secondary conditions clarified". The medical documents provided do not indicate that any of the above criteria were met. As such, the request for FCE (functional capacity evaluation) is not medically necessary.

Elbow brace: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), elbow chapter, splinting (padding).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 26.

Decision rationale: There are a few different studies noted in the Occupational Medicine Practice Guidelines available on the use of Epicondylgia supports (bands, braces and straps). One such study noted in the guidelines concluded that after 3 months of brace treatment, individuals experienced a decrease in pain, improvement in functionality of the arm, and pain-free grip strength in patients with lateral epicondylitis. The benefits lasted up to 12 months after cessation of the brace. Quality studies are available on brace use in acute, subacute, and chronic lateral epicondylgia sufferers, but the braces used in the research studies are not widely used in the United States. Braces are a non-invasive, low cost option with few side effects. MTUS recommends their use, therefore the Elbow brace is medically necessary.