

<b>Case Number:</b>	CM15-0176486		
<b>Date Assigned:</b>	09/15/2015	<b>Date of Injury:</b>	02/12/2014
<b>Decision Date:</b>	11/05/2015	<b>UR Denial Date:</b>	08/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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: Internal 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 51 year old male, who sustained an industrial-work injury on 2-12-14. A review of the medical records indicates that the injured worker is undergoing treatment for right wrist tears and ulnar positive radiance, status post open reduction internal fixation (ORIF) right shoulder, left shoulder strain, tennis elbow right elbow, cervical strain, cervical disc herniation and degenerative disc disease (DDD) , radiculitis right upper extremity, low back pain with degenerative disc disease (DDD) with osteophytes, right knee medial and lateral meniscus tears, left knee strain, headaches, stress, anxiety and post-traumatic stress disorder. Treatment to date has included pain medication, Diclofenac since at least 6-13-14, Omeprazole since at least 2014, acupuncture, aqua therapy (unknown amount), right knee and right shoulder surgery 2-5-15, physical therapy at least 8-10, and other modalities. Medical records dated (2-13-15 to 7-24-15) indicate that the injured worker complains of pain in the neck, shoulders, right wrist, low back and left knee. The medical record dated 2-13-15 the physician indicates that he continues to have neck pain and right wrist pain rated 8 out of 10 on pain scale. He is awaiting second opinion for right wrist surgery. The medical records also indicate worsening of the activities of daily living due to the pain. Per the treating physician report dated 7-24-15 the injured worker has not returned to work and is temporarily totally disabled as of 7-24-15 to 8-23-15. The physical exam dated 7-24-15 reveals positive tenderness over the cervical muscles, decreased range of motion with extension at 30 degrees with pain, and lateral bending right and left 30 degrees with pain. The left shoulder range of motion is decreased and there is positive tenderness over the right lateral epicondyle. The right wrist reveals dorsal tenderness, pain with resisted pronation, flexion

and extension of the wrist, and positive lift-off test. The physician indicates that he continues to improve and he recommends aqua therapy to improve symptoms and function, Diclofenac for anti-inflammatory, Omeprazole to reduce Nonsteroidal anti-inflammatory drug gastritis and prophylaxis, second opinion consult for right wrist and Functional Capacity Evaluation (FCE) to determine accurate impairment rating. The Magnetic resonance imaging Magnetic Resonance Imaging (MRI) of the cervical spine date 7-18-14 reveals decreased range of motion with flexion and extension which may reflect myospasm, disc desiccation, Hemangioma, disc herniation which causes stenosis, and broad based posterior disc herniation causing stenosis of the spinal canal. The Magnetic Resonance Imaging (MRI) of the right wrist dated 10-21-14 reveals increased signal near the median nerve that may represent carpal tunnel syndrome, neutral ulnar variance with subtle ulnotriquetral impaction, non-communicating tear in the triangular fibrocartilage complex at the ulnar insertion, tear in the radiolunate ligament, minimal fluid in the distal radiolunar, radioscapoid and pisotriquetral joint spaces, cyst like structure anterior to the ulnar styloid that may represent ganglion or synovial cyst and bone cyst in the capitate. The original Utilization review dated 8-6-15 non-certified a request for Diclofenac XR 100mg #60 as Diclofenac is not recommended per the guidelines as first line treatment due to increased risk and medical records do not establish why the injured worker cannot use first-line Non-steroidal anti-inflammatory drugs such as Naproxen, non-certified a request for Omeprazole 20mg #60 as the Non-steroidal anti-inflammatory drug is being non-certified the medical necessity for the proton pump inhibitor is not established per guidelines, non-certified a request for Physical Therapy 2 times a week x 3 weeks as the medical records do not establish how many aqua therapy and physical therapy sessions the injured worker has completed to date or evidence of functional improvement as a result of the previously rendered care, non-certified a request for Cervical Epidural Steroid Injection C7-T1 as medical records do not establish evidence of a neural compressive lesion on the cervical Magnetic Resonance Imaging (MRI) and per guidelines, radiculopathy must be documented by physical exam and corroborated by imaging or electrodiagnostic studies, non-certified a request for Second opinion consultation with a Hand Specialist as the medical records do not establish medical necessity for hand surgeon consult, modified a request for Cognitive Behavioral Therapy and Mindfulness Therapy with Biofeedback 2-3 times week x 6 weeks modified to allow for psychology referral: Cognitive Behavioral Therapy and Mindfulness Therapy with Biofeedback 6 sessions only and pending the response to the treatment, further recommendations may be made, and non-certified a request for Functional Capacity Assessment as the medical records do not establish prior unsuccessful return to work attempts.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Diclofenac XR 100mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Online Version), Diclofenac.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Anti-inflammatory medications.

**Decision rationale:** As per MTUS Guidelines Diclofenac is a non-steroidal anti-inflammatory medication (NSAID). This type of medication is recommended for the treatment of chronic Osteoarthritis. Dosages > 150 mg/day PO are not recommended. Ankylosing spondylitis: 25 mg PO 4 times a day with an extra 25-mg dose at bedtime if necessary therapy. Voltaren-XR should only be used as chronic maintenance therapy ODG state that NSAIDs (non-steroidal anti-inflammatory drugs). Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The documentation indicates the patient has been maintained on long-term NSAID therapy, but there has been no compelling evidence presented by the provider to document that the patient has had any significant improvements from this medication. The injured worker complains of pain in the neck, shoulders, right wrist, low back and left knee. Review of Medical Records do not clarify that previous use of this medication has been effective in this injured worker for maintaining any functional improvement. Medical necessity for the requested treatment has not been established. The requested treatment: Diclofenac XR 100mg #60 is not medically necessary.

**Omeprazole 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Proton pump inhibitors (PPIs).

**Decision rationale:** As per the ODG guidelines, Omeprazole is a proton pump inhibitor. The CA MTUS guidelines indicate that proton pump inhibitors are recommended in those patients who are risk for gastrointestinal events and no cardiovascular disease. The gastrointestinal event risk factors include: age over 65 years, history of peptic ulcer, GI (gastrointestinal) bleeding or perforation, concurrent use of ASA (aspirin), corticosteroids, and/or an anticoagulant, or high dose or multiple oral NSAID (non-steroidal anti-inflammatory drug) use. There is no evidence documented that this injured worker is at risk of gastrointestinal events or has any concerning GI complaints. Also there is no evidence of a history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of aspirin, corticosteroids, anticoagulants, or high dose or multiple oral NSAID use. Based on the available information provided for review, the medical necessity for Omeprazole has not been established. Therefore, the request is not medically necessary.

**Physical Therapy 2 times a week x 3 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** The prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy. MTUS recommends 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records indicate the injured worker had no functional benefit from prior physical therapy visits. Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The request does not clearly specify for what body parts it is requested. The request for physical therapy is not medically necessary and appropriate.

**Aqua Therapy 2 times a week for 3 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter--Aquatic therapy.

**Decision rationale:** Both MTUS and ODG recommend Aquatic Therapy as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. In this case of injured worker, submitted medical records lack clear documentation of meaningful functional improvement from prior Aquatic Therapy. Therefore, the determination about the medical necessity cannot be made. The requested Treatment: Aqua Therapy 2 times a week for 3 weeks is not medically necessary.

**Cervical Epidural Steroid Injection C7-T1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Pain Chapter-- ODG Epidural steroid injections (ESIs).

**Decision rationale:** This requested treatment for Epidural steroid injections (ESIs) is evaluated in light of the CA MTUS and the Official Disability Guidelines (ODG) recommendations. The California MTUS Chronic Pain Medical Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 epidural steroid injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection. Epidural steroid injections can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing with home exercise. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement of radicular lumbosacral pain, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendations for use of epidural steroid injections to treat radicular cervical pain. ODG criteria do not recommend additional epidural steroid injections, if significant improvement is not achieved with an initial treatment. ODG also state there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Review of medical documentation does not specify neurological deficits within a dermatomal pattern. The notes from treating provider do not indicate abnormal neurological exam. There is no evidence of nerve entrapment or radiculopathy. Based on the cited guidelines and the submitted documentation, the request for cervical epidural steroid injection is not medically necessary and appropriate.

**Second opinion consultation with a Hand Specialist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2004, Chapter 7, page 127, Independent Medical Examination & Consultation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Office visits.

**Decision rationale:** Official Disability Guidelines (ODG) recommends Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The notes submitted by treating provider do not indicate any failure of ongoing conservative measures. Medical records are not clear about any significant change in injured worker's chronic symptoms. The notes submitted by treating provider do not indicate why referral is needed. Considering the given guidelines, the requested treatment: Second opinion consultation with a Hand Specialist is not medically necessary.

**Cognitive Behavioral Therapy and Mindfulness Therapy with Biofeedback 2-3 times week x 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress Chapter (Online Version), Cognitive therapy for depression, ODG Psychotherapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological evaluations, Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Office visits.

**Decision rationale:** MTUS recommends Psychological treatment for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. MTUS state Consider a psych consult if there is evidence of depression, anxiety or irritability At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.ODG state Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. Medical records of injured worker do give information about the complaints of anxiety and depression that will make it necessary for the requested treatment. However, guidelines recommend 6 CBT as initial treatment. As the request exceeds the recommended guidelines, medical necessity of the requested treatment: Cognitive Behavioral Therapy and Mindfulness Therapy with Biofeedback 2-3 times week x 6 weeks has not been established. Therefore, the request is not medically necessary.

**Functional Capacity Assessment:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2004, Chapter 7, page 137 and 138, Independent Medical Examinations & Consultations (FCE).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Work conditioning, work hardening.

**Decision rationale:** The CA MTUS ACOEM Practice Guidelines state a number of functional assessment tools are available, including functional capacity examination when reassessing function and functional recovery. The Official Disability Guide do not recommend proceeding with a functional capacity evaluation if the sole purpose is to determine a worker's effort or

compliance and/or if the worker has returned to work without having an ergonomic assessment arranged. Within the medical information available for review, the injured worker has chronic pain and there is no indication the injured worker is close or at maximum-medical-improvement (MMI). There is no documentation of prior unsuccessful return-to-work (RTW) attempts. Medical records lack information about job description, physical demand level and specific work-related tasks. Also records do not document injured worker's return to work goals. The medical necessity of the requested treatment: Functional Capacity Assessment has not been established. Therefore, the request is not medically necessary.