

<b>Case Number:</b>	CM14-0129851		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	05/07/2013
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	07/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records, presented for review, indicate that this 19-year-old individual was reportedly injured on 5/7/2013. The mechanism of injury was noted as a lifting injury. The most recent progress note, dated 2/27/2014, indicated that there were ongoing complaints of neck, upper back, right shoulder, right upper extremity, and low back pains. The physical examination demonstrated cervical spine had 3+ tenderness to the bilateral paraspinal muscles from C2-C7 and bilateral suboccipital muscles. Cervical range of motion was decreased with pain. Axial compression test was positive bilaterally. Right bicep and brachioradialis reflex was decreased. C5, C6, and C8 dermatomes were decreased to the light touch on the right. The right C5, C6, and C8 myotomes showed some weakness. Lumbar spine had decreased range of motion with pain, positive Kemp's test bilaterally. Achilles reflex was decreased bilaterally. Shoulder had +4 spasm and tenderness to the right rotator cuff muscles and right upper shoulder muscles. Decreased range of motion was with pain. There were positive Speed's test, positive Supraspinatus test, and positive Codman's test on the right. Right elbow had 3+ spasm and tenderness to palpation to the right lateral and medial epicondyle. Decreased range of motion was with pain. Diagnostic imaging studies included an MRI the cervical spine dated 5/14/2014. It revealed an unremarkable MRI of the cervical spine. Previous treatment included medications and conservative treatment. A request had been made for NCV of the bilateral lower extremities, lidocaine 6%, gabapentin 10%, tramadol 10% 180 gm 2 refills, flurbiprofen 15%, cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5% 180 gm 2 Refills, and functional capacity evaluation and was not certified in the pre-authorization process on 7/18/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NCV Bilateral Lower Extremities: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Electrodiagnostic testing (EMG/NCS)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG -TWC/ODG Integrated Treatment/Disability Duration Guidelines; Low Back - Lumbar & Thoracic (Acute & Chronic) - Nerve Conduction Studies - (updated 07/03/14).

**Decision rationale:** MTUS/ACOEM guidelines do not address this request. ODG does not recommend nerve conduction velocities (NCV) of the lower extremities for low back pain. As such, this request is considered not medically necessary.

**Lidocaine 6%, Gabapentin 10%, Tramadol 10%, 180 Gm, 2 Refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

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

**Decision rationale:** MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As such, this request is not considered medically necessary.

**Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5%, 180 Gm, 2 Refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

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

**Decision rationale:** MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As such, this request is not considered medically necessary.

**Qualified Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) - Independent Medical Examinations and Consultations - Referral Issues and the IME Process - (electronically sited).

**Decision rationale:** ACOEM practice guidelines indicated that functional capacity evaluations are recommended to "translate medical impairment into functional limitations and determine work capability." Medical records provided for review indicate that the employee is not working, and there is no evidence of return to work plan for which work restrictions would be necessary. The request for a functional capacity evaluation is not medically necessary or appropriate.