

<b>Case Number:</b>	CM14-0046225		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	01/22/2010
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	03/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2014

### 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 Orthopedic Surgery and is licensed to practice in California. 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 patient is a 74-year-old male was reportedly injured on 1/22/2010. The mechanism of injury was noted as a fall. The most recent progress note, dated 3/3/2014, indicated that there were ongoing complaints of neck pain, right shoulder pain, and low back pain. The physical examination demonstrated cervical spine: Positive tenderness over the paracervical muscles bilaterally. Limited range of motion was with pain. Positive foraminal compression test bilaterally. Shoulder depression test was positive bilaterally. Lumbar spine: Positive tenderness to palpation of the pair lumbar muscles bilaterally. Two plus muscle spasm noted. Limited range of motion was with pain and spasm bilaterally. Valsalva maneuver test was present. Kemp's test was positive bilaterally. Right shoulder: Positive tenderness to palpation over the rotator cuff and with positive spasm. Limited range of motion. Positive impingement. Positive Empty Can supraspinatus test. Bilateral upper and lower reflexes were within normal limits. Bilateral upper and lower muscle strength were within normal limits. Diagnostic imaging studies included mention of MRIs of the right shoulder, and lumbar spine performed on 2/5/2014; however, official radiological report was not available for review. Previous treatment included previous surgery, physical therapy, and medications. A request was made for a functional capacity evaluation, TGHOT topical cream, FluriFlex topical cream and was not certified in the pre-authorization process on 3/26/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**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 (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Chronic Pain Programs Page(s): 30-34 OF 127. 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 cited).

**Decision rationale:** ACOEM Guidelines support the use of functional capacity evaluations to determine about the current work capability and, if requested, the current objective functional capacity of the examinee. The examiner is responsible for determining whether the impairment results in functional limitations and to inform the examinee and the employer about the examinee's abilities and limitations. The physician should state whether the work restrictions are based on limited capacity, risk of harm, or subjective examinee tolerance for the activity in question. However, after reviewing the medical documentation, it was noted the treating physician was requesting a surgical procedure, which consists of right shoulder manipulation under anesthesia and lysis of adhesions. Therefore, the request for Functional Capacity Evaluation is not medically necessary and appropriate.

**Retrospective TGHOT Topical Cream:** 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 111-113 OF 127.

**Decision rationale:** TGHOT (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/0.05%) Cream: MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental and any compound product, that contains at least one drug (or drug class), that is not recommended, is not recommended. The guidelines indicate Gabapentin is not recommended for topical application. Additionally, the guidelines recommend the use of capsaicin only as an option for patients who are intolerant of other treatments and there is no indication that an increase over a 0.025% formulation would be effective. In this case, there was no documentation in the records submitted indicating the claimant was intolerant of other treatments. The request for topical TGHOT is not in accordance with the MTUS Guidelines. Therefore, the retrospective request for TGHOT Cream is not medically necessary and appropriate.

**Retrospective Flurflex Topical Cream:** 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 111-113 OF 127.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental and any compound product, that contains at least one drug (or drug class), that is not recommended, is not recommended. The guidelines note there is little evidence to support the use of topical NSAIDs (flurbiprofen) for treatment of osteoarthritis of the spine, hip or shoulder and there is no evidence to support the use for neuropathic pain. Additionally, the guidelines state there was no evidence to support the use of topical Cyclobenzaprine (a muscle relaxant). The guidelines do not support the use of Flurbiprofen or Cyclobenzaprine in a topical formulation. Therefore, the request for FluriFlex Topical Cream is not medically necessary and appropriate.