

<b>Case Number:</b>	CM14-0187598		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	08/14/2014
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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 Internal Medicine 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:

Pursuant to the progress note dated September 22, 2014, the IW complains of pain to the neck, lumbar spine, left arm, and coccyx. He also reports depression, insomnia, and sleep disturbances. Objective physical findings revealed tenderness to palpation (TTP) and muscle spasm of the cervical spine. There is TTP along the coccyx with pain in the mid coccyx level. There is TTP about the lumbar paravertebral muscles and sacroiliac joints bilaterally. The provider is requesting a Functional Capacity Evaluation, Naproxen 550mg, Colace, and Cyclobenzaprine/Ketoprofen/Lidocaine cream as needed. A clinical note dated December 4, 2014 indicates the following work status: Temporary Total Disability for 6 weeks.

### 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:** Decision based on MTUS ACOEM Page(s): 137-138.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7, Pages 137-138

**Decision rationale:** Pursuant to the ACOEM, a functional capacity evaluation is not medically necessary. The guidelines state and employer may request a functional capacity evaluation to further assess current work capability. Though functional capacity evaluations are widely used

and promoted, it is important for physicians and others to understand the limitations and pitfalls of these evaluations. Functional capacity evaluations may establish physical abilities and also facilitate the examinee/employer relationship for return to work. However functional capacity evaluations can be deliberately simplified evaluations based on multiple assumptions and subjective factors which are not always apparent to them requesting physicians. There is little scientific evidence confirming functional capacity evaluations predict an individual's actual capacity to perform in the workplace. For these reasons, it is problematic to rely solely upon functional capacity evaluation results for determination of work capabilities and restrictions. In this case, the injured worker is a 57-year-old man with a date of injury August 14, 2014. The injury sustained was to the lower back, sacrum and coccyx. The working diagnoses are cervical spine strain; left arm radiculopathy; lumbar spine strain; and coccydynia. There is no indication the injured worker has reached maximal medical improvement of functional capacity evaluation would not be clinically indicated if the injured worker was not at maximum medical improvement. Additionally, there is little scientific evidence confirming functional capacity evaluations predict an individual's actual capacity to perform in the workplace. Consequently, a functional capacity evaluation is not medically necessary. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, functional capacity evaluation is not necessary.

**Cyclo/Keto/Lido Cream 240gm (unspecified strength/dosage): 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)- Treatment in Workers Comp -[www.odgtreatment.com](http://www.odgtreatment.com); Topical Analgesic

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Cyclo/Keto/Lido cream #240 g is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants anticonvulsants failed. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Ketoprofen is not FDA approved. Lidocaine, other than in patch form, is not approved whether cream, lotion or gel for neuropathic pain. Cyclobenzaprine is not approved as a topical product. In this case, the treating physician requested a topical compound with cyclobenzaprine, ketoprofen, lidocaine, all in cream form. Neither ketoprofen, lidocaine nor cyclobenzaprine are recommended. Any compounded product that contains at least one drug (ketoprofen, lidocaine and cyclobenzaprine) that is not recommended, is not recommended. Consequently, topical cyclobenzaprine/ketoprofen/lidocaine cream #240 g is not medically necessary.