

<b>Case Number:</b>	CM14-0200985		
<b>Date Assigned:</b>	12/11/2014	<b>Date of Injury:</b>	07/12/2012
<b>Decision Date:</b>	02/03/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 Occupational 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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic shoulder pain, elbow pain, forearm pain, knee pain, leg pain, neck pain, mid back pain, low back pain, ankle pain, and wrist pain reportedly associated with an industrial injury of July 12, 2012. In a Utilization Review Report dated November 10, 2014, the claims administrator denied a capsaicin-containing topical compound. In separate Utilization Review Reports of November 10 and November 11, 2014, a neurosurgery consultation, ophthalmology evaluation, and functional capacity evaluation were also denied. The claims administrator referenced non-MTUS Chapter 7 ACOEM Guidelines to deny the functional capacity evaluation, mislabeling the same as originating from the MTUS. An August 15, 2014 progress note was also cited in the rationale. The applicant's attorney subsequently appealed. In a handwritten progress note dated May 15, 2014, difficult to follow, not entirely legible, the applicant reported multifocal complaints of neck, mid back, low back, bilateral shoulder, bilateral wrist, and bilateral elbow pain, 2-3/10. Large portions of the note were entirely illegible. MRI imaging of the bilateral shoulders, MRI imaging of the bilateral elbows, pain management consultation, unspecified amounts of physical therapy, a general orthopedic consultation, and electrodiagnostic testing of bilateral upper extremities were sought while the applicant was given a rather proscriptive 15-pound lifting limitation. It did not appear that the applicant was working with said limitations in place, although this was not explicitly stated. On June 12, 2014, MRI imaging of multiple body parts, including the bilateral shoulders and bilaterals elbows, an internal medicine consultation, eight sessions of physical therapy, and a general orthopedic referral were endorsed via preprinted checkboxes, with little to no narrative commentary. An ophthalmology consultation was also endorsed. Multifocal complaints of neck pain, shoulder pain, elbow pain, wrist pain, and mid back pain, 2-3/10, were noted. Physical therapy and acupuncture were also

sought. There was no seeming mention of any ophthalmology issue on this date. Menthoderm, cyclobenzaprine, Naprosyn, and Prilosec were renewed. A functional capacity evaluation of some kind was performed on May 30, 2014, the results of which were not clearly reported. A 28-pound lifting limitation was suggested. The functional capacity evaluation suggested that the applicant tested within the light physical demand level (PDL). In a handwritten note dated October 21, 2014, genetic testing, an internal medicine consultation, pain management consultation, an ophthalmology consultation, and an orthopedic versus neurosurgery consultation were sought, along with further FCE testing. Work restrictions were again endorsed, although it did not appear that the applicant was working. Further acupuncture was sought. Multifocal neck, mid back, low back, bilateral shoulders, bilateral wrists, bilateral knees, and bilateral foot and ankle pain were evident. There was no mention made of any ophthalmology issues on this date, either.

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

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

**Compound Capsaicin 8% Patch, multiple body parts:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Capsaicin Page(s): 28.

**Decision rationale:** As noted on page 28 of the MTUS Chronic Pain Medical Treatment Guidelines, topical capsaicin is not recommended except as a last-line agent, for applicants who have not responded to or are intolerant of other treatments. In this case, however, the applicant's concurrent usage of multiple first-line oral pharmaceuticals, including Flexeril, Naprosyn, etc., several of which were refilled on June 12, 2014, effectively obviated the need for the capsaicin-containing topical compounded patch. Therefore, the request is not medically necessary.

**Outpatient Neurosurgeon Consult, multiple body parts:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 180; 306.

**Decision rationale:** As noted in the MTUS Guideline in ACOEM Chapter 12, page 306, applicants with low back pain complaints, without findings of significant nerve root compromise, rarely benefit from either surgical consultation or surgery. Similarly, the MTUS Guideline in ACOEM Chapter 8, page 180 also notes that applicants with neck or mid back pain complaints without associated findings of nerve root compromise rarely benefit from either surgical consultation or surgery. In this case, the attending provider has not established the presence of a

lesion amenable to surgical correction insofar as the either surgical spine and/or lumbar spine are concerned. The applicant seemingly has multifocal pain complaints reportedly a function of cumulative trauma at work. The attending provider's handwritten progress notes and preprinted checkboxes did not set forth a compelling rationale for pursuit of a neurosurgeon/neurosurgery consultation at issue. There was no mention of the applicant's having a lesion amenable to surgical correction insofar as the cervical spine, thoracic spine, and/or lumbar spine were concerned. Therefore, the request is not medically necessary.

**Outpatient Ophthalmologist initial evaluation, multiple body parts: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation CA MTUS ACOEM Occupational Medicine Practice Guidelines, Chapter 7, page 127

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 16 Eye Chapter Page(s): Algorithm 16-4, page 468.

**Decision rationale:** While the MTUS Guideline in ACOEM Chapter 16, Algorithm 16-4, page 468 does suggest referral to an ophthalmologist in applicants with slow-to-recover occupational eye complaints, in particular applicants with suspected intraocular foreign bodies, in this case, however, it was not clearly stated what was sought. It was not clearly stated what was suspected. The attending provider did not state what ophthalmic symptoms were present which would warrant the proposed ophthalmologist evaluation. ACOEM Chapter 16, Algorithm 16-4 further states that assessment of an applicant's visual acuity should generally be performed before an ophthalmologist evaluation is sought and/or considered. Here, the attending provider did not detail or document the applicant's visual acuity on any of the office visits referenced above, nor did the attending provider outline what ophthalmic issues and/or symptoms were present which would compel the ophthalmologist evaluation at issue. Therefore, the request is not medically necessary.

**Outpatient FCE BUE, multiple body parts: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 137-138. Decision based on Non-MTUS Citation 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.

**Decision rationale:** While the MTUS Guideline in ACOEM Chapter 2, page 21 does suggest considering a functional capacity evaluation when necessary to translate medical impairment into functional limitations so as to determine work capability, in this case, however, the applicant is seemingly off of work. A rather proscriptive 15-pound lifting limitation was imposed, seemingly unchanged, from visit to visit. It did not appear that the applicant was working with said limitations in place. The attending provider did not outline how the proposed FCE would influence or alter the treatment plan and/or influence the applicant's returning to work. It is

further noted that the applicant had already received multiple FCE tests throughout 2014 alone, the results of which were not clearly reported. None of the previously performed FCEs, furthermore, resulted in the attending provider's altering the applicant's work restrictions and/or returning the applicant to work. It is not clear, in short, why additional functional capacity testing is being sought in the clinical and vocational context present here. Therefore, the request is not medically necessary.