

<b>Case Number:</b>	CM15-0163100		
<b>Date Assigned:</b>	08/31/2015	<b>Date of Injury:</b>	10/03/2013
<b>Decision Date:</b>	10/15/2015	<b>UR Denial Date:</b>	08/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 52-year-old female who sustained an industrial injury on 10-03-2013. She reported that she was staying in a hotel overnight for work and that she turned on the water for the shower, reached for a towel, slipped, and fell backwards. She was found to have a hairline fracture in her left hand first metacarpal and soft tissue injuries of the upper extremities and neck. According to a progress report dated 07-30-2015, the injured worker was seen for re-evaluation for her neck. Her pain was a little worse. She had dermatitis for almost 2 weeks and was not able to do acupuncture or physical therapy. Medications were helpful. She was taking Flexeril as needed for muscle spasm, Norco for severe pain and Naproxen or Ibuprofen for anti-inflammation. She also took Omeprazole to prevent gastrointestinal upset from taking oral non-steroidal anti-inflammatory drugs. She did a home exercise program and used H-wave regularly. She was hoping to return to work soon and wanted a functional capacity evaluation. She was currently attending cognitive behavioral therapy. Pain was described as aching and stabbing in the neck and traps. Pain was rated 6 on a scale of 1-10 without medications and 3 with medications. Impression included chronic pain syndrome, neck pain, cervical disc pain, cervical degenerative disc disease, cervical stenosis and myalgia. Physical examination of the cervical spine demonstrated 5 of 5 bilateral upper extremity strength, diminished sensation in the left upper arm, no clonus or increased tone, moderate tenderness over the cervical paraspinals, minimal facet joints were tender to palpation at bilateral C4-5 and C5-6 and increase pain with extension. Norco, Flexeril and Naproxen were dispensed. The provider noted that opioids were necessary for chronic intractable pain. Medications were helpful. Pain was tolerable with her

medications. She was able to work around the house and enjoy family activities with her pain tolerable. She was to proceed with physical therapy as directed. She was temporarily totally disabled until 09-01-2015. Currently under review is the request for a Functional Capacity Evaluation and Flexeril 7.5 mg (dispensed 07-30-2015) quantity 60.

### **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 Neck and Upper Back Complaints 2004, and Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ACOEM chapter 7, page 137-139.

**Decision rationale:** Based on the 7/30/15 progress report provided by the treating physician, this patient presents with aching, stabbing, and slightly worsening neck pain rated 6/10 without medications and 3/10 with medications. The treater has asked for FUNCTIONAL CAPACITY EVALUATION on 7/30/15. The patient's diagnosis per request for authorization dated 7/31/15 is neck pain. The patient is s/p 2 weeks of dermatitis, which prevented her from doing acupuncture and physical therapy per 7/30/15 report. The patient states that medications are helpful, which include Flexeril for muscle spasm, Norco for severe pain, Naproxen or Ibuprofen for anti-inflammation per 7/30/15 report. The patient is currently doing a home exercise program daily per 6/23/15 report. The patient states that H-wave helps with neck pain per 6/23/15 report. The patient's work status is temporarily totally disabled until 9/1/15 per 6/23/15 report. MTUS does not discuss functional capacity evaluations. ACOEM chapter 7, page 137-139 states that the "examiner is responsible for determining whether the impairment results in functional limitations... The employer or claim administrator may request functional ability evaluations... may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial." ACOEM further states, "There is little scientific evidence confirming that FCE's predict an individual's actual capacity to perform in the workplace." In this case, a request for functional capacity evaluation is noted in progress report dated 7/30/15. The treater is requesting a functional capacity evaluation "for specific work restrictions to avoid worsening of pain" per 7/30/15 report. In addition, the patient is awaiting a course of physical therapy and would like to return to work soon. However, ACOEM states, "there is little scientific evidence confirming that FCE's predict an individual's actual capacity to perform in the workplace." Additionally, there is no request from the employer or claims administrator. The treating physician's estimation regarding the patient's work restrictions is just as good. Furthermore, routine Functional Capacity Evaluation is not supported by ACOEM. Hence, the request IS NOT medically necessary.

**Flexeril 7.5mg (dispensed 7/30/15) Qty: 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): Carisoprodol (Soma), Muscle relaxants (for pain).

**Decision rationale:** Based on the 7/30/15 progress report provided by the treating physician, this patient presents with aching, stabbing, and slightly worsening neck pain rated 6/10 without medications and 3/10 with medications. The treater has asked for FLEXERIL 7.5MG (DISPENSED 7/30/15) QTY 60 on 7/30/15. The patient's diagnosis per request for authorization dated 7/31/15 is neck pain. The patient is s/p 2 weeks of dermatitis, which prevented her from doing acupuncture and physical therapy per 7/30/15 report. The patient states that medications are helpful, which include Flexeril for muscle spasm, Norco for severe pain, Naproxen or Ibuprofen for anti-inflammation per 7/30/15 report. The patient is currently doing a home exercise program daily per 6/23/15 report. The patient states that H-wave helps with neck pain per 6/23/15 report. The patient's work status is temporarily totally disabled until 9/1/15 per 6/23/15 report. MTUS Chronic Pain Medical Treatment Guidelines 2009 pg 63-66 and Muscle relaxants section states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, Cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy. MTUS, Chronic Pain Medication Guidelines 2009, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. In this case, the Cyclobenzaprine was first noted in progress report dated 4/14/15 and in reports dated 5/12/15 and 7/30/15. The treater states that medications that include Cyclobenzaprine are "helpful" per 7/30/15. While Cyclobenzaprine may benefit the patient, MTUS does not support long-term use of this medication beyond a 2 to 3 week period. The current request for 60 tabs, in addition to prior 3 months of usage, exceeds guideline recommendations. Hence, the request IS NOT medically necessary.