

<b>Case Number:</b>	CM14-0150017		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	01/11/2011
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 54-year-old female who has submitted a claim for myofasciitis cervical and lumbosacral spine, bilateral rotator cuff tear and bilateral shoulder osteoarthritis, associated with an industrial injury date of January 11, 2011. Medical records from 2014 were reviewed. The patient complained of constant slight to moderate right shoulder pain radiating to the neck. She was status post 2 arthroscopic surgeries of the left shoulder. Examination of the right shoulder showed tenderness over the deltoid and rotator cuff muscles; positive crepitus; decreased range of motion; positive impingement and supraspinatus tests; and decreased muscle strength of the right shoulder at 4/5. Latest examination of the left shoulder was no available. X-ray of the right shoulder on December 4, 2013 showed mild narrowing of the shoulder joint space with minimal spurring of the inferior glenoid lip; while MRI of the right shoulder on May 23, 2014 revealed supraspinatus/infraspinatus partial tear with tendinosis. The diagnoses were myofasciitis cervical spine, left side worse than right; myofasciitis lumbosacral spine; degenerative joint disease, right shoulder; status post arthroscopic surgery x2, left shoulder; adhesive capsulitis with partial tear of the supraspinatus, left shoulder; osteoarthritis, left shoulder; insomnia; right shoulder sprain/strain secondary to compensation over the left shoulder; and right shoulder impingement syndrome, bursitis, rotator cuff tear and SLAP tear. Treatment to date has included Cymbalta, Mobic, capsaicin gel, physical therapy, chiropractic therapy, aqua therapy, and left shoulder surgeries. Utilization review from August 19, 2014 denied the request for Functional Capacity Exam (FCE). It was not stated how much of the testing relates to the injured body parts, duration of testing, and how patient efforts will be evaluated. The request for Capsaicin gel 0.025% #1 was also denied because there was no evidence to show that pain was not successfully controlled by conventional therapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **FUNCTIONAL CAPACITY EXAM (FCE): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM CHAPTER 7, PAGE 137

**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) Chapter 7, page(s) 132-139 Official Disability Guidelines (ODG) Fitness for Duty Section, Functional Capacity Evaluation

**Decision rationale:** As stated on pages 132-139 of the CA MTUS ACOEM Guidelines, functional capacity evaluations (FCEs) may be ordered by the treating physician if the physician feels the information from such testing is crucial. FCEs may establish physical abilities and facilitate the return to work. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace. Furthermore, ODG states that FCE should be considered when there are prior unsuccessful RTW attempts and when patient is close to or at MMI. The FCE should not be performed if the worker has not returned to work and an ergonomic assessment has not been arranged. In this case, there was no mention of prior unsuccessful return to work attempts. The guideline does not recommend FCE when the worker has not returned to work. Moreover, the documents do not reflect that the patient is close to or at MMI. The medical necessity has not been established. There was no documented rationale for FCE, and it is unclear how this may affect management. Therefore, the request for functional capacity evaluation is not medically necessary.

### **CAPSAICIN GEL 0.025% #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin Page(s): 28-29.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option if there was failure to respond or intolerance to other treatments. The guideline states there is no current indication that an increase over a 0.025% formulation of capsaicin would provide any further efficacy. In this case, capsaicin gel 0.025% use was noted since June 2014. However, there was no evidence of continued analgesia and functional benefit from its use. Furthermore, the medical records do not show intolerance to oral pain medications or failure of other conservative treatments to manage pain. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request for CAPSAICIN GEL 0.025% #1 is not medically necessary.

