MAXIMUS Federal Services

Case Number:	CM13-0015426		
Date Assigned:	03/12/2014	Date of Injury:	04/06/2009
Decision Date:	04/28/2014	UR Denial Date:	07/26/2013
Priority:	Standard	Application Received:	08/22/2013

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 patient is a 55-year-old male with dates of cumulative trauma injuries on 4/06/2009-1/01/2010. The most current secondary treating physician's progress report, dated 2/11/2014, lists subjective complaints as occasional sharp chest pain that lasts less than five minutes. He notes improving acid reflux and constipation and worsening sleep quality. The patient's medical history is remarkable for a left knee surgery (8/19/2011); history of coronary heart disease, and stent placement. The objective findings indicate that an examination of the chest reveals the lungs to be clear to auscultation. There are no rales or wheezes appreciated. The patient's abdomen is soft with normoactive bowel sounds, non-tender and no guarding, and general bloating noted. An examination of the extremities revealed no clubbing or cyanosis. There is 2+ bilateral lower extremity pitting edema. The extremities examination of tenderness and range of motion was differed to the appropriate specialist. The industrial related diagnoses include: 1. Constipation; 2. Gastroesophageal reflux disease, secondary to non-steroidal anti-inflammatory drugs (NSAIDs); and 3. Obstructive sleep apnea. In an orthopedic evaluation dated 09/03/2013, the patient complained of left shoulder pain, rating it 6/10, low back pain rating at 6/10, and left knee pain rating it 6/10. An examination of lumbar spine showed decreased range of motion in all planes, and mild decrease in motor strength in the lower extremities. An examination of left knee showed effusion, and tenderness over the medial joint line. The range of motion was limited and painful upon flexion. There was a positive McMurray test, with the remainder of the knee exam being normal. The diagnoses include: Left shoulder labral tear, left shoulder rotator cuff syndrome, low back syndrome with bilateral radicular symptoms, left knee medial meniscal tear, status post left knee surgery, and joint pain. There is no documentation in any of the notes that the patient has attempted to go back to work in either full capacity or modified duty.

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 cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty, Functional Capacity Evaluation (FCE).

Decision rationale: The Official Disability Guidelines recommend a functional capacity evaluation (FCE) if: 1. Case management is hampered by complex issues such as: Prior unsuccessful return to work (RTW) attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed exploration of a worker's abilities; and 2. Timing is appropriate, such as close or at maximum medical improvement (MMI) and all key medical reports secured, and additional/secondary conditions have been clarified. There is no documentation that the patient has tried to return to work or other explanation in the record citing any of the above.