

<b>Case Number:</b>	CM13-0025843		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	08/01/2012
<b>Decision Date:</b>	01/22/2014	<b>UR Denial Date:</b>	08/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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 41-year-old male who reported an injury on 08/01/2012. The patient has been treated for chronic low back pain with bilateral leg pain, which he has rated at a 7/10 on a pain scale. The most recent clinical date for review is from 08/21/2013, which noted that the patient's pain had remained unchanged since his previous visit from 07/11/2013. On 05/15/2013, the patient underwent a magnetic resonance imaging (MRI) of the lumbar spine, which revealed at the L3-4 disc level, a posterior disc protrusion of the nucleus pulposus, indenting the anterior portion of the lumbosacral sac. Also, bony hypertrophy of the articular facet was present. The neural foramina appeared patent. The lateral recesses were clear, and there was a normal ligamentum flavum. At the L4-5 level, there was noted degenerative dehiscence with a 1.5 mm central disc protrusion of the nucleus pulposus indenting the anterior portion of the lumbosacral sac. There was mild bony hypertrophy of the articular facet present, and the mild lateral recess stenosis was present bilaterally. The patient had been treated with oral medications, physical therapy and epidural steroid injections. The physician is now requesting a Functional Capacity Evaluation.

### 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 base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Chapter 7, pages 137-138, online edition.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 696-698.

**Decision rationale:** The MTUS/ACOEM state there is no recommendation for or against Functional Capacity Evaluations (FCEs) for chronic, stable low back pain or completed postoperative recovery. They are an option when a physician thinks that the information may be helpful to attempt to objectify worker capability vis-à-vis either a specific job or general job requirements. If there are circumstances where a patient is not progressing as anticipated at 6 to 8 weeks, an FCE can evaluate functional status and patient performance in order to match performance to specific job demands, particularly in instances where those demands are medium to heavy. If a physician is comfortable describing work ability without an FCE, there is no requirement to do this testing. On the documentation dated 06/20/2013, the patient was on modified duties regarding his employment. It further stated that he would be on modified duties from 06/20/2013 through 08/05/2013 with the following restrictions: the patient may interchange between sitting/standing positions as needed for comfort; limited climbing, bending, stooping, kneeling, squatting and lifting. With the most recent clinical date as 08/21/2013, it is unclear what the patient's current medical status is and if he has returned to full duty status at this time. Without updated clinical information, the medical necessity for a functional capacity evaluation is unknown.