

Case Number:	CM13-0040840		
Date Assigned:	12/20/2013	Date of Injury:	04/25/2012
Decision Date:	02/18/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/29/2013

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 rehabilitation and is licensed to practice in Illinois. 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 46-year-old female who reported a work related injury on 04/25/2012 due to tripping and catching herself from falling. The patient's diagnoses include lumbar discopathy, herniated nucleus pulposus, and left lower extremity radiculopathy. The patient has undergone physical therapy treatments and injections. Request has been made for 1 Functional Capacity Evaluation between 09/21/2013 and 11/23/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decision for 1 functional capacity evaluation (Align Networks) between 9/21/213 and 11/23/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.

Decision rationale: Recent clinical documentation stated the patient still complained of residual symptomatology in her lumbar spine and had chronic complaints of cervicgia. Furthermore, the symptomatology in the patient's left wrist was essentially unchanged. The patient was noted to have painful and restricted cervical range of motion with dysesthesia at the C5-7 dermatomes

and tenderness at the left wrist volar aspect with positive Tinel's and Phalen's signs. Tenderness was noted to have lumbar spine with terminal motion and seated nerve root test was positive. Recommendation was made per recent clinical documentation for a comprehensive home exercise program and the patient was noted to require further treatment and care as part of her future medical care. California Medical Treatment Guidelines indicate determining limitations for a patient is not really a medical issue and clinicians are simply being asked to provide an independent assessment of what the patient is currently able and unable to do. Under some circumstances, this can best be done by ordering a Functional Capacity Evaluation of the patient. There was no rationale given in the submitted clinical documentation for the request for 1 Functional Capacity Evaluation for the patient. The clinical note dated 08/15/2013 stated the patient was working full duty and may continue to do so. Therefore, the decision for 1 Functional Capacity Evaluation between 09/21/2013 and 11/23/2013 is non-certified.