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| Case Number: | CM13-0049120 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 05/28/2013 |
| Decision Date: | 03/26/2014 | UR Denial Date: | 10/22/2013 |
| Priority: | Standard | Application Received: | 11/07/2013 |

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 Occupational 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 27-year-old male with date of injury 05/28/2013. He was injured when a student attacked him at work, jumping on his back and beating him with closed fists. The attacking student apparently twisted the patient's head and neck causing him to fall, striking his head upon an adjacent wall. The patient's primary treating physician is [REDACTED]. Much of the medical record is handwritten and eligible. It appears that the request for a functional capacity evaluation was made on 09/20/2013. There is no explanation as to why the FCE has been ordered. Diagnoses listed by [REDACTED] in his typewritten PR-2 of 07/17/2013 are: 1. Right second finger sprain/strain, no fracture on x-ray, 2. Cervical spine sprain/strain with upper extremity paresthesia, rule out herniated nucleus pulposus, internal derangement, spondylolistheses, fasciitis, radiculopathy versus other neuropathy, 3. Thoracic spine sprain/strain, rule out disc injury, 4. Lumbar spine sprain/strain with a lower extremity paresthesia, rule out herniated nucleus pulposus/internal derangement/spondylolisthesis/fasciitis/radiculopathy versus other neuropathy, 5. Right shoulder sprain/strain, rule out internal derangement, 6. left shoulder sprain/strain, rule out internal derangement/greater trochanteric bursitis/iliotibial band, 7. Stress, 8. Rule out anxiety/depression, 9. Insomnia, and 10. Possible overdose on July 4, 2013 with hospitalization by report until July 7, 2013 at [REDACTED]. In the handwritten chart note of 09/20/13, it appears that the patient is complaining of pain in the cervical, thoracic, and lumbar spine which he rates a 9/10. He complains of pain in his right second finger as 3/10 and both shoulders which he rates as 3/10. The patient is complaining of pain in both hips which is rated 6-7/10. By 09/20/2013, the patient had undergone a very extensive radiological workup including an MRI of the cervical spine, thoracic spine, lumbar spine, bilateral shoulders, and bilateral hips. He had also undergone arthrogram followed by MRI of bilateral shoulders. The

MRIs of the cervical, thoracic, and lumbar spine are essentially normal with only mild degenerative changes. He has early signs of osteoarthritis in both shoulders, and the arthrogram shows a small tear of the supraspinatus tendon in the left rotator cuff.

IMR ISSUES, DECISIONS AND RATIONALES

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

One 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)

Decision rationale: No documentation in the medical record for any of the following:
Guidelines for performing an FCE: If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if: 1. Case management is hampered by complex issues such as: - Prior unsuccessful RTW attempts. - Conflicting medical reporting on precautions and/or fitness for modified job. - Injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate: - Close or at MMI/all key medical reports secured. - Additional/secondary conditions clarified. Do not proceed with an FCE if: - The sole purpose is to determine a worker's effort or compliance. - The worker has returned to work and an ergonomic assessment has not been arranged. (WSIB, 2003) The medical record does not appear to have documentation of any of the criteria needed for authorization of a functional capacity evaluation.