

Case Number:	CM13-0063033		
Date Assigned:	12/30/2013	Date of Injury:	02/26/2013
Decision Date:	06/06/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/09/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 48-year-old male who was injured on 02/26/2013. He sustained an injury from a 30-foot steel bar joist, weighing approximately 400 to 500 pounds, fell on his lower extremities. He sustained fractures to the tibia and fibula. The patient underwent ORIF on 02/27/2013 of bimalleolar ankle fracture with spanning plate of segmental comminuted fibular fracture with ORIF syndesmosis the fluoroscopy use and splint application and repeat surgery in March 2013; Removal of hardware left ankle on 03/19/2013. He underwent two surgeries at the L4-5 and L5-S1 levels in 2000. Initial Consult dated 11/04/2013 documented the patient stated he complained of progressive pain in his right ankle and left ankle over the past nine months. He complained of pain in the mid-back, lower back, right knee, and left ankle. His lower back pain radiated down to his left lower extremity. The pain was associated with numbness, tingling, and weakness in the left foot. The pain was constant in frequency and moderate in intensity. He rated his pain at 4-7/10, 4 at best and 7 at worst. He described the pain as sharp, dull, aching, and burning. His pain gets aggravated by walking, prolonged standing, and prolonged walking. He could only lift or carry items weighing less than 50 pounds. His pain was relieved with taking medication and applying ice over the affected area. He stated he experienced relief of back pain when leaning forward or leaning on a shopping cart. He reported no bowel or bladder incontinence or any bowel or bladder problems. He reported the pain in his lower back was 90% of his pain, left leg was 10% of his pain. He stated that his lower back pain was worse when bending forward. He stated he could walk half a block before having to stop because of the pain. The patient reported being involved in a work-related accident in 2000 when he sustained an injury to his back. Objective findings on exam revealed range of motion was restricted with flexion limited to 110 degrees limited by pain but normal extension. Crepitus was not noted with active movement. There was tenderness to palpation noted over the medial joint line. The left knee was stable to

valgus stress in extension and at 30 degrees. The left knee was able to varus stress in extension and at 30 degrees. There was negative anterior drawer, 1A Lachman test and negative pivot shift test. There was negative posterior drawer test and reverse pivot shift test. There was mild effusion in the left knee joint. The patellar grind test was negative; McMurray's test was positive. The left ankle movements were restricted with plantar flexion limited to 5 degrees limited by pain and dorsiflexion limited to 5 degrees limited by pain. There was tenderness noted over the lateral ankle, into the lateral leg and anterior ankle. The patient was able to bear weight on his right ankle with pain. On motor examination, gastrocnemius appeared atrophied on the left. The patient moved all extremities well. On sensory examination, light touch sensation was patchy in distribution; dysesthesias were present over. The patient was diagnosed with foot pain and knee pain. MRI of the left knee was requested as well as FCE to determine the patient's functional level as he was thinking that he would like to return to his previous work. PR2 dated 10/07/2013 indicated the patient had complaints of persistent pain along his ankle. He stated the steroid injection exacerbated pain for the first 3 weeks. He would still like to continue with strengthening exercises. Currently, he still has too much pain. Objective findings on exam revealed the left ankle demonstrated minimal swelling. The incisions were healed. He was able to dorsiflex to 5 degrees and plantar flex to 30 degrees. His ankle was stable. There was generalized tenderness to palpation throughout the left ankle. There was no calf tenderness. The patient was status post revision of ORIF left ankle. Residual symptoms may take a year to fully resolve as discussed with the patient. He was given another 6 weeks on modified work duties to continue working on strengthening exercises on his left ankle.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) 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 & ENVIRONMENTAL MEDICINE, 2ND EDITION, CHAPTER 7 INDEPENDENT MEDICAL EXAMINATIONS & CONSULTATIONS (PP 132-139).

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

Decision rationale: Regarding the request for functional capacity evaluation, the Official Disability Guidelines (ODG) support FCEs when the patient is at or near MMI and case management is hampered by complex issues such as prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job, and/or injuries that require detailed exploration of a worker's abilities. Within the documentation available for review, it does not appear that the patient is approaching MMI or that case management is hampered by complex issues as noted above. In the absence of such documentation, the currently requested functional capacity evaluation is not medically necessary.