

Case Number:	CM14-0002166		
Date Assigned:	01/24/2014	Date of Injury:	10/20/2010
Decision Date:	06/27/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	01/07/2014

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 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 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 injured worker is a 67-year-old female who reported an injury on 10/20/2010. The mechanism of injury was a slip and fall. Per the MRI dated 04/29/2013 of the lumbar spine, there was mild to moderate disc degeneration at L4-5. There was a 3 mm broad-based posterior disc protrusion. There was also left greater than right L4-5 ligamentum flavum hypertrophy and facet joint arthropathy. There was moderate to severe left and mild right L4-5 foraminal encroachment. There was anatomic potential for impingement on the existing left L4 nerve. There was also moderate left and mild to moderate right L4-5 lateral recess stenosis. There was mild disc degeneration at L5-S1. There was a 2 to 3 mm left greater than right broad-based posterior disc protrusion. Right greater than left facet joint arthropathy at L5-S1 was also identified, contributing to mild bilateral L5-S1 lateral recess stenosis. Per the electrodiagnostic study dated 05/07/2013, the injured worker was reported to have chronic right L5 radiculopathy and chronic left L4 radiculopathy; there was no electrodiagnostic evidence of generalized peripheral neuropathy seen in the lower extremity nerves. Per the clinical note dated 05/10/2013, the injured worker reported pain to her right shoulder, right arm, low back, and bilateral hips. In 12/2012, the injured worker underwent 1 injection to the right shoulder with no benefit noted, and the injured worker reported increased pain afterwards. The injured worker reported numbness of the right hand and fingers on occasion, which was radiating from the right shoulder. The injured worker reported intermittent right shoulder pain and cracking. There was numbness and tingling of the shoulder, upper arm, and right hand, with all fingers of the hand on occasion. The injured worker reported intermittent low back pain that radiated into both hips and down the back of the left leg, to the left calf with cramping. There was numbness and tingling of the low back on occasion, as well as the left leg. On physical exam, there was tenderness to palpation over the anterior and lateral aspects of the right shoulder. Neer's, Hawkins, and O'Brien's tests

were positive. Range of motion values for bilateral shoulders were within normal limits. Deep tendon reflexes were symmetrical in the biceps, triceps, and brachioradialis. Range of motion to the lumbar spine was noted to be normal. X-rays of the bilateral shoulders showed mild diffuse osteopenia. X-rays of the lumbar spine showed large bridging osteophytes on the left side of the spine between L2 and L4. Facet arthropathy was seen throughout the lumbar spine, most notable from L4-S1. Diffuse osteopenia was seen in the lumbar area. X-rays of the pelvis showed diffuse osteopenia. The diagnosis reported for the injured worker included right shoulder sprain or strain with severe tendinosis of the supraspinatus tendon, with a large full-thickness tear and moderate hypertrophic degenerative changes of the AC joint, and moderate fluid within the subacromial/subdeltoid bursa with extensive synovial thickening; and lumbar spine sprain/strain, with a 3 mm disc protrusion at L4-5 with mild to moderate disc degeneration and left greater than right ligamentum flavum hypertrophy and facet joint arthropathy, with moderate to severe left and mild right foraminal encroachment. The Request for Authorization for medical treatment was not provided in the documentation. The provider's rationale for the functional capacity evaluation was not provided within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

INITIAL FUNCTIONAL CAPACITY EVALUATION: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for duty, Functional capacity evaluation.

Decision rationale: Per ACOEM guidelines it may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient. Per the Official Disability guidelines functional capacity evaluations are not recommended for routine use as a part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. Both job-specific and comprehensive functional capacity evaluations can be valuable tools in clinical decision-making for the injured worker; however, functional capacity evaluations is an extremely complex and multifaceted process. There was a lack of documentation regarding the intended purpose of this evaluation. In addition, the documentation was unclear regarding the injured worker's desire to return to work and the capacity in which they would do so. Therefore, the request for the initial Functional Capacity Evaluation is not medically necessary.