

Case Number:	CM14-0009026		
Date Assigned:	02/12/2014	Date of Injury:	04/04/2007
Decision Date:	07/25/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	01/21/2014

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 Occupational Medicine 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 33-year-old male who has submitted a claim for lumbar disc herniation and lumbar disc degeneration, multiple levels associated with an industrial injury date of April 4, 2007. Medical records from 2012-2013 were reviewed. The patient complained of low back pain. The pain was characterized as sharp and was aggravated by kneeling and bending. There was associated numbness and tingling radiating into the buttocks, thighs, legs, and bottom of feet. Physical examination showed spasm and tenderness to the bilateral lumbar paraspinal muscles from L1 to S1 and multifidus. Range of motion of the lumbar spine was limited and painful. Kemp's, straight leg raise, Braggard's, and Yeoman's test was positive bilaterally. Hamstrings reflex and Achilles reflex was decreased. There was decreased sensation on the L4, L5 and S1 dermatomes on the left. MRI of the lumbar spine (undated) revealed disc extrusion at L3-L4 and L4-L5, and a grade 1 spondylolytic anterolisthesis of L5 which appears to encroach on the left L5 nerve root. Official report of the imaging study was not available for review. Treatment to date has included medications, physical therapy, chiropractic therapy, lumbar epidural steroid injections, and activity modification. Utilization review, dated January 8, 2014 denied the request for functional capacity evaluation because the worker has returned to work and an ergonomic assessment has not been arranged.

IMR ISSUES, DECISIONS AND RATIONALES

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

QUALIFIED FUNCTIONAL CAPACITY EVALUATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, page 137-138 and the Non-MTUS Official Disability Guidelines (ODG), Fitness for Duty, Functional capacity evaluation (FCE).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, page(s) 132-139; Official Disability Guidelines (ODG), Fitness for Duty, Functional capacity evaluation (FCE).

Decision rationale: According to pages 132-139 of the ACOEM Guidelines referenced by CA MTUS, functional capacity evaluations (FCEs) may be ordered by the treating physician if the physician feels the information from such testing is crucial. Though FCEs are widely used and promoted, it is important for physicians to understand the limitations and pitfalls of these evaluations. FCEs may establish physical abilities and facilitate the return to work. However, FCEs can be deliberately simplified evaluations based on multiple assumptions and subjective factors, which are not always apparent to the requesting physician. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace. In addition, ODG states that an FCE should be considered when case management is hampered by complex issues (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), and timing is appropriate (Close to or at MMI/all key medical reports secured, and additional/secondary conditions have been clarified). In this case, there was no discussion regarding the indication for an FCE. There was also no discussion regarding return-to-work attempts or whether the patient is close or at maximum medical improvement, which are conditions wherein an FCE may be considered. The patient remains to be temporary totally disabled. There is no clear indication for an FCE and whether this will be crucial to the management of the patient. Therefore, the request for qualified functional capacity evaluation is not medically necessary.