

<b>Case Number:</b>	CM14-0013785		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	03/04/2007
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	01/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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 48-year-old male who has submitted a claim for multilevel lumbar spondylosis worse at L4-L5 associated with an industrial injury date of March 4, 2007. The medical records from 2011-2013 were reviewed. The patient complained of progressive low back pain. There was associated numbness and pain to the top of his right foot. Standing for any prolonged period of time resulted in leg and knee weakness. Physical examination showed moderate tenderness in the lumbar region. Extension increases pain. There was also guarding with motion. Straight leg raise test was negative. There was decreased sensation on the right L5 nerve distribution. Motor strength was intact. MRI of the lumbar spine, dated October 17, 2013, revealed T12-L1 a 2.9 mm anterior disc bulge, mild spondylosis anteriorly at T12 and L1; mild spondylosis anteriorly at L1 and L2; at L2-L3 a 2.2 mm circumferential disc bulge which mildly impresses on the thecal sac, and mild spondylosis anteriorly at L2 and L3; and at L3-L4 mild desiccation and 3.1 mm circumferential disc bulge which mildly impresses on the thecal sac and produces mild bilateral neural foraminal narrowing. Electrodiagnostic report, dated May 23, 2013, showed electrophysiological evidence of mild right L5 sensory radiculopathy and right S1 sensory radiculopathy. Treatment to date has included medications, physical therapy, and activity modification. In a utilization review, dated January 27, 2014, denied the request for physical therapy 2 x 6 weeks because there was lack of information documenting recent physical therapy or outcomes of physical therapy as basis to consider certification. The request for functional capacity evaluation was denied as well because its purpose was unclear since the patient was continuing to work and that the work was less demanding.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY, 2 X 6 WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** As stated on pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. In this case, the rationale for the request was to help increase his core strength and help decrease his use of pain medications. According to the progress report dated December 16, 2013, the patient previously underwent an unknown number of physical therapy sessions in the remote past. There was no documentation of the previous physical therapy visits and there was no description regarding objective benefits derived from these sessions or a treatment plan with defined functional gains and goals. Recent progress reports did not document any acute exacerbation or flare-up of symptoms. Patient is also expected to be well-versed in a self-directed home exercise program by now. Furthermore, the present request failed to specify the body part to be treated. Therefore, the request for physical therapy, 2 x 6 weeks is not medically necessary.

**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.

**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, the rationale of the request was to find out whether or not the patient is ready to go back to work with regular duty. However, progress report dated December 16, 2013 stated that patient continues to work and that it is a slightly less demanding job. The submitted progress notes did not document functional and work restrictions. Furthermore, there was no discussion whether the patient is close or at maximum medical improvement. There is no clear indication for FCE at this time. Therefore, the request for functional capacity evaluation is not medically necessary.