

Case Number:	CM14-0141763		
Date Assigned:	09/10/2014	Date of Injury:	10/31/2012
Decision Date:	11/17/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/02/2014

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 Internal 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 injured worker (IW) is a 34-year-old man with a date of injury of October 31, 2012. The IW was lifting a piece of wood with a nail in it. He did not notice the nail and it got stuck in his right knee. This caused him to lose his balance and fall about 10 feet. Pursuant to the First Report of Occupational Injury dated July 28, 2014, which was handwritten with parts being illegible, the IW complains of right knee pain, and low back pain. Objective findings reveal L/S bilateral side tenderness, Flex 65, ext 30, lateral bend 35/30, ext knee. Knees Right prepatellar tenderness, flex 135, ext 6?, flex pain. Diagnoses include: Lumbar radiculopathy, and right knee internal derangement. Treatment: UA for toxicology and med compliance, topical compound creams ordered, FCE, MRI L/S Right knee. EMG/NCV lower ext. TEN unit, pain management. There was a follow-up progress report dated July 23, 2014 (date does not coincide as being a follow-up as the date of service is 7/23/14, which would indicate the note was written prior to the first occupational report) that states the IW complains of pain mostly in his right knee and low back, which comes and goes. Most of the pain occurs when he is walking, the knee locks. The rest of the subjective complaint is illegible in the handwritten report. Objective finding in the handwritten note that is partly illegible indicates back pain going into the low back and down the back of the (?) leg and left thigh, into the (?) calf. Cramping, and numbness when walking. He feels weakness like it's going to collapse. Diagnoses documented are: Lumbar sprain/strain and right knee sprain. Treatment includes: Ortho pain management; chiropractic PT - 2 times a week for 6 weeks; acupuncture, 1 time a week for 6 weeks; UA for drug compliance, topical cream, and L/S knee support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Exam: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, Functional Capacity Evaluations, page 137-138

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Capacity Evaluation Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Functional Capacity Evaluation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Functional Capacity Evaluations, pages 137-138

Decision rationale: Pursuant to the American College of Occupational and Environmental Medicine (ACOEM), Chronic Pain Medical Treatment and Official Disability Guidelines, the functional capacity evaluation is not medically necessary. The guidelines provide though functional capacity evaluations (FCEs) are widely used and promoted, it is important for physicians to understand the limitations and pitfalls of these evaluations. Functional capacity evaluations may establish physical abilities and facilitate the examinee/employer relationship for the return to work. However, functional capacity evaluations can be deliberately simplified based on multiple assumptions and subjective factors, which are not always apparent to the requesting physician. There is little scientific evidence confirming that functional capacity evaluations predicted individual's actual capacity to work in the workplace; it reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's ability. As with any other behavior, and individual's performance on the functional capacity evaluation is probably its limits by multiple nonmedical factors other than physical impairments. In this case, there is no evidence presented or a discussion with the injured worker and the injured worker's employer regarding return to work at a specific job for which a functional capacity evaluation may be there is no specific justification or rationale as to medical necessity indicated. Based on the clinical information in the medical record and the peer reviewed, evidence based guidelines, the FCE is not medically necessary.