

<b>Case Number:</b>	CM14-0192407		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	09/05/2014
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	10/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Family 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:

This 24-year-old housekeeper reported an injury to her right knee after she felt a pop in the knee while kneeling on 9/5/14. It was her second day at a new job. The available records contain a single report from the treating physician, a 10/9/14 initial evaluation of the patient. Objective findings included a notation that patient had a limping distorted gait and was using crutches and a knee immobilizer. There was swelling and jointline tenderness of the right knee with a positive McMurray's sign. Orthopedic testing could not be completed due to pain and the patient's need to keep her knee in full extension. Diagnosis was right knee sprain/strain, rule out internal derangement. The plan included a prescription for naproxen, a referral for "computerized ranges of motion", and a request for an MRI of the right knee. Work status was temporarily totally disabled for 6 weeks. The records also contain a California Doctor's First Report form with the same date (10/9/14) which lists required future treatments as "FCE, UDT and MRI of the right knee STAT". No rationale for the FCE (functional capacity evaluation) or UDT (usually called UDS or urine drug screen) is documented on either form. The treating physician submitted a medical necessity form for the FCE on the same date with a checked pre-printed statement reading "It is very important for the PTP or QME/AME to recognize that the assessment of the ADLs start at the beginning of the treatment as opposed to having the ADLs assessed for the first time at MMI". The MRI of the right knee was performed 10/24/14 with entirely normal results. The request for FCE (functional capacity exam) was non-certified in a 10/17/14 UR report on the basis that further treatment was indicated and that the patient was not near maximal medical improvement, with a citation from ODG. This decision was appealed and again non-certified in UR on 10/29/14 on the same basis. The request for a UDS was non-certified in UR on 10/17/14 on the basis that the patient was not taking opioid medications, with a citation from MTUS Chronic Pain, Opioids section.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **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 Official Disability Guidelines; regarding Functional capacity evaluation (FCE) ; Guidelines for performing an FCE

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81,Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation

**Decision rationale:** The ACOEM citation above states that in order to determine a patient's work limitations, 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. The work hardening reference states a criterion for entry into a work hardening program may be the performance of a Functional capacity evaluation (FCE) that shows consistent results with maximal effort, which demonstrate capacities below an employer-verified physical demands analysis. (In other words, an FCE may be required to show that a patient is not physically capable of performing his or her job, and needs a work hardening program.)The ODG reference states that FCEs are recommended prior to admission to a work hardening program, with preference for assessments tailored to a specific task or job. They are not recommended for generic assessments in which the question is whether someone can do any type of job generally. FCEs should be considered when case management is hampered by complex issues such as prior unsuccessful attempts to return to work, or conflicting medical reports on an employee's fitness for a modified job; when timing is appropriate and the worker is at or near maximum medical improvement and all secondary conditions are clarified. An FCE should not be performed if its sole purpose is to determine a worker's effort or compliance, or if the worker has returned to work and an ergonomic assessment has not been arranged.The clinical documentation in this case does not support the performance of an FCE. This patient was injured on her second day of work at a new job, and is highly unlikely to be returning to it. She is nowhere near maximum medical improvement, and is still in the acute phase of her injury. An FCE in this setting would involve testing someone who is presumed to be well below her usual capacity to see if she can do any type of job generally. Work capacity evaluations are not designed to determine if patients are able to perform ADLs (activities of daily living)--they are designed to determine the patient's capacity to work. Determining the ability to perform activities of daily living (ADLs) is easily done by asking the patient what daily activities she is or is not able to do. It is unclear why the treating physician feels he needs an FCE to accomplish this assessment. Based on the clinical documentation provided for my review and on the evidence-based citations above, an FCE is not medically necessary because the patient is nowhere near maximal medical improvement, because she does not appear to have any job for which her capabilities could be tested, and because an FCE is not required to determine a patient's ability to perform activities of daily living.

## **1 Urine drug test: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines Opioids Chapter 2004, Summary of Recommendations and Evidence

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Therapeutic Trial of Opioids; Opioids, Ongoing Management; Opioids, S. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Urine Drug Testing, criteria for use

**Decision rationale:** Urine drug tests are also called urine drug screens or UDS's. Per the MTUS guidelines cited above, an assessment of the likelihood for substance abuse should be made before a therapeutic trial of opioid use is begun. The section on ongoing management of opioid use recommends that regular assessment for aberrant drug taking behavior should be performed. Drug screens should be used in patients with issues of abuse, addiction or poor pain control. The section on steps to avoid misuse/addiction recommends frequent random urine toxicology screens. Per the ODG reference cited, clinicians should be clear on the indication for using a UDS prior to ordering one. Testing frequency should be determined by assessing the patient's risk for misuse, with low-risk patients to receive random testing no more than twice per year. Documentation of the reasoning for testing frequency, need for confirmatory testing, and of risk assessment is particularly important in stable patients with no evidence of risk factors or previous aberrant drug behavior. The clinical documentation in this case does not support the performance of a urine drug test. This patient is not taking an opioid, and there is no documentation of plans to have her do so. There is no documentation of the reason for ordering a UDS, or of any assessment of the patient that shows issues of abuse, addiction or poor pain control in this patient. Based on the evidence-based citations above and on the clinical documentation provided for review, a urine drug test is not medically necessary in this case because the patient is not taking an opioid, because there are no documented plans to have her take an opioid, and because there is no documentation of the patient's risk for misuse or of any other concern that would require the performance of a UDS.