

Case Number:	CM14-0196649		
Date Assigned:	12/04/2014	Date of Injury:	01/07/2010
Decision Date:	01/22/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/24/2014

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 Iowa. 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 38 year-old female with a date of injury of 1/7/2010. A review of the medical documentation indicates that the patient is undergoing treatment for neck, shoulder, and wrist pain. Subjective complaints (10/24/2014) include pain in the cervical spine, right shoulder, and right and left wrist; swelling in both wrists, and difficulty with fine hand manipulation to include pinching, squeezing, and gripping. Objective findings (10/24/2014) include mild tenderness in the cervical (C6-7) paraspinal, supraspinatus, and infraspinatus muscles; tenderness in the right acromioclavicular joint; decreased cervical and right shoulder range of motion; decreased wrist range of motion; and decreased grip strength bilaterally. Diagnoses include cervical spine disc protrusions, muscle spasm, right shoulder tendinosis, arthrosis, de Quervain's tenosynovitis, right wrist tenosynovitis, left wrist ganglion/synovial cyst, s/p right wrist surgery, adjustment disorder with mixed anxiety and depression. The patient has undergone studies to include MRI of the cervical spine (date unknown), which showed C4-6 disc protrusion; MRI of the forearm (4/2012), which reportedly showed fluid collections in the extensor tendon sheaths; MRI of the elbow (date unknown), which was reportedly normal. The patient has previously undergone right wrist surgery, home exercise, and medication therapy. A utilization review dated 11/4/2014 did not certify the request for Functional Capacity Evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation: 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, pages 231-139 and on the Non-MTUS Official Disability Guidelines (ODG), Functional Capacity Evaluation (FCE)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE)

Decision rationale: According to MTUS guidelines, ACOEM recommends use of a functional capacity evaluation (FCE) when necessary to translate medical impairment into functional limitations and determine work capability, in the event that a more precise delineation is needed than can be elicited from routine physical examination. ODG also does not recommend as part of routine evaluation, and only recommends in certain circumstances, such as prior to a Work Hardening program, when case management is complicated by complex issues, or at an appropriate time to assist placement or medical determination. ODG recommends timing of FCE when the patient is close or at MMI and all key medical reports are secured and additional or secondary conditions are clarified. The medical documentation available outlines the patient's limitations and the latest visit indicates there continues to be similar pain as before although some new symptoms have occurred. The documentation states that the patient is approaching P&S status (permanent and stationary), but it is not clear that the treating physician is attempting a final medical determination at this time or that additional information on the patient's capabilities is necessary to determine work status. The case does appear to be somewhat complex in nature, but the documentation does not state that more precise information is needed in addition to the physician's routine physical examination, and it is not clear if all key reports and secondary conditions have been addressed. Therefore, the request for a functional capacity evaluation is not medically necessary.