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| Case Number: | CM14-0198795 | | |
| Date Assigned: | 12/09/2014 | Date of Injury: | 01/18/2005 |
| Decision Date: | 02/25/2015 | UR Denial Date: | 10/28/2014 |
| Priority: | Standard | Application Received: | 11/26/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 64-year-old woman with a date of injury of January 18, 2005. The mechanism of injury is not documented in the medical record. The injured worker's diagnoses according to the May 5, 2014 progress note are status post lumbar spine fusion in 2010 and 2011 with residuals; lumbar disc syndrome; lumbar radiculitis; bilateral carpal tunnel syndrome; GERD; hypertension; anxiety; depression; insomnia; and urinary incontinence. Prior treatment has included 2 previous lumbar surgeries, epidural steroid injection, physical therapy, and aquatic therapy. The most recent note from the primary treating physician (orthopedic surgeon) is dated May 5, 2014. There is a request for authorization (RFA) for a functional capacity evaluation (FCE) dated September 15, 2014 from the same physician; however, there are no recent clinical notes from the requesting provider pertaining to the request. According to the progress report dated May 5, 2014, the IW had complains of bilateral wrist pain and low back pain. Examination of the lumbar spine revealed tenderness to palpation and decreased range of motion. The treatment plan included request authorizations for internal medicine, urology consult, topical creams, and psychiatric evaluation. There was no discussion regarding a FCE. There is a neurosurgical re-evaluation dated October 15, 2015. According to the note, the IW complains of ongoing lower back pain. Examination of the lumbar spine reveals tenderness to palpation over the L3-L4 facet joint bilaterally. There is also tenderness over the sciatic notch bilaterally. Range of motion is limited by pain in all directions. There was no discussion of a FCE. The current request is for a 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 function: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 75-92. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty

MAXIMUS guideline: Decision based on MTUS ACOEM, Postsurgical Treatment Guidelines.

Decision rationale: Pursuant to the ACOEM practice guidelines, a functional capacity evaluation is not medically necessary. The guidelines state the examiner is responsible for determining whether impairment results of functional limitations and to inform the examinee and employer about the examinee's abilities and limitations. The physician should state whether work restrictions are based on limited capacity, risk of harm or subjective examinee's tolerance for the activity in question. There is little scientific evidence confirming functional capacity evaluations predict an individual's actual capacity to perform in the workplace. For these reasons, it is problematic to rely solely upon functional capacity evaluation results for determination of current work capabilities and restrictions. In this case, the injured worker's diagnoses according to the May 5, 2014 progress note are status post lumbar spine fusion in 2010 and 2011 with residuals; lumbar disc syndrome; lumbar radiculitis; bilateral carpal tunnel syndrome; GERD; hypertension; anxiety; depression; insomnia; and urinary incontinence. Prior treatment has included 2 previous lumbar surgeries, epidural steroid injection, physical therapy, and aquatic therapy. The most recent note from the primary treating physician (orthopedic surgeon) is dated May 5, 2014. There is a request for authorization (RFA) for a functional capacity evaluation (FCE) dated September 15, 2014 from the same physician; however, there are no recent clinical notes from the requesting provider pertaining to the request. According to the progress report dated May 5, 2014, the IW had complains of bilateral wrist pain and low back pain. Examination of the lumbar spine revealed tenderness to palpation and decreased range of motion. The treatment plan included request authorizations for internal medicine, urology consult, topical creams, and psychiatric evaluation. There was no discussion regarding a FCE. Therefore, the Functional capacity evaluation is not medically necessary.