

<b>Case Number:</b>	CM15-0008408		
<b>Date Assigned:</b>	01/23/2015	<b>Date of Injury:</b>	03/23/2010
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	12/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2015

### 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, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 is a 69-year-old male who reported an injury on 03/23/2010 due to an unspecified mechanism of injury. On 12/17/2014, he presented for an evaluation. He reported constant 10/10 headaches radiating into the neck and back with numbness and tingling, 10/10 constant cervical spine pain, 10/10 constant cervicothoracic pain, 10/10 constant severe lumbar spine pain, and 10/10 right and left shoulder and right and left leg pain. A physical examination of the cervical spine showed decreased range of motion with flexion at 35 degrees, extension at 45 degrees, left and right lateral bending at 30 degrees, and left and right rotation at 60 degrees. Cervical compression tests caused pain and Spurling's test was negative. Thoracic spine also showed decreased and painful range of motion with flexion at 25 degrees, and left and right rotation at 15 degrees. The lumbar spine showed decreased range of motion with flexion at 40 degrees, extension right and left lateral bend at 15 degrees. Kemp's caused pain and straight leg raise caused pain bilaterally. The bilateral shoulders were also decreased in range of motion with associated pain and shoulder apprehension caused pain. Supraspinatus test caused pain in the left shoulder, as well as shoulder apprehension tests bilaterally. He was diagnosed with headache, lumbar pain, right shoulder pain, left shoulder pain, displacement of cervical intervertebral disc without myelopathy, thoracic IVD without myelopathy, and displacement of the lumbar IVD without myelopathy. The treatment plan was for an outpatient final functional capacity evaluation. The rationale for treatment was not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient Final Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for duty, FCE.

**Decision rationale:** ACOEM guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work, has conflicting medical reports, the patient had an injury that required a detailed exploration of a workers abilities, a worker is close to maximum medical improvement and/or additional or secondary conditions have been clarified. However, the evaluation should not be performed if the main purpose is to determine a worker's effort or compliance or the worker has returned to work and an ergonomic assessment has not been arranged. It is recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. There was a lack of documentation showing that the injured worker meets any of the criteria with which a functional capacity evaluation would be considered medically necessary. In addition, a clear rationale was not provided for the medical necessity of an additional functional capacity evaluation as it appears the injured worker has already undergone 1. In the absence of this information, the request would not be supported by the evidence based guidelines. As such, the request is not medically necessary.