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| Case Number: | CM15-0181204 | | |
| Date Assigned: | 09/22/2015 | Date of Injury: | 10/17/2005 |
| Decision Date: | 11/03/2015 | UR Denial Date: | 09/01/2015 |
| Priority: | Standard | Application Received: | 09/15/2015 |

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, Hawaii

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 63 year old female, who sustained an industrial injury on October 17, 2005. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as having synovitis and tenosynovitis, cervical radiculopathy, lumbosacral radiculopathy, shoulder impingement, knee tendinitis-bursitis, wrist tendinitis-bursitis, elbow tendinitis-bursitis and ankle tendinitis-bursitis. Treatment to date has included diagnostic studies, surgery, physical therapy and medications. She stated that physical therapy helped to "reduce" pain, facilitate activities of daily living, "increase" functional capacity and helped to reduce the need for taking oral medications. On August 26, 2015, the injured worker complained of locking and catching of her left knee. She reported residual bilateral shoulder pain, bilateral elbow pain, wrist pain, right knee pain, bilateral ankle pain and low back pain. Physical examination revealed global tenderness about her musculoskeletal system. Left knee exam revealed locking and catching. McMurray's sign was positive. An MRI scan of the left knee and urine toxicology screening were recommended. On September 1, 2015, utilization review denied a request for functional capacity evaluation and urine toxicology screen.

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 Official Disability Guidelines (ODG), Fitness for duty chapter - Functional capacity evaluation (FCE).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Functional Capacity Evaluations, chapter 7, page 137.

Decision rationale: The patient presents with bilateral shoulder, bilateral elbow, bilateral wrist, bilateral knee, bilateral ankle and low back pain. The current request is for Functional Capacity Evaluation. The treating physician's report dated 07/15/2015 (11B) states, "I have reviewed her Job Description, and feel it is necessary that she undergo a Functional Capacity Evaluation to assess her level of impairment and determine any necessary work restrictions in order to prevent further injury at the work place in the future." The ACOEM Guidelines page 137 to 139 on functional capacity evaluations states that functional capacity evaluations may establish physical abilities, and also facilitate the examinee/employer relationship before return to work. In addition, ACOEM states, "There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE 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 abilities. As with any behavior, an individual's performance on an FCE is probably influenced by multiple nonmedical factors other than physical impairments. For these reasons, it is problematic to rely solely upon the FCE results for determination of correct work capability and restrictions." The 07/15/2015 (12B) report notes that the patient is doing well and is approaching maximum medical improvement. While the physician has provided a rationale for the request, the patient's job description was not documented. Furthermore, routine FCE's are not supported by the guidelines unless requested by an administrator, employer, or if the information is crucial. The current request is not medically necessary.

Urine toxicology screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, screening for risk of addiction (tests). Decision based on Non-MTUS Citation ODG, Pain Chapter, Urine Drug Testing.

Decision rationale: The patient presents with bilateral shoulder, bilateral elbow, bilateral wrist, bilateral knee, bilateral ankle and low back pain. The current request is for Urine Toxicology Screen. The treating physician's report dated 07/15/2015 (11B) states, "Finally, I am also requesting authorization for the patient to be administered a urine toxicology screening to check the efficacy of the prescribed medications." No urine drug screen reports were made available for review. The MTUS guidelines do not specifically address how frequent urine drug screens should be obtained for various-risk opiate users. However, ODG guidelines provide clear recommendations. For low-risk opiate users, once yearly urine drug screen is recommended

following initial screening within the first 6 months. Medical records show that the patient's current list of medications include: Tramadol and Hydrocodone. In this case, while the physician has not documented the patient's "risk assessment" ODG recommends once yearly urine drug screen and a follow-up within the first 6 months for a total of 2 per year for low-risk opiate users. The current request is medically necessary.