

<b>Case Number:</b>	CM15-0182673		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	07/23/2007
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2015

### 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, 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:

This is a 50-year-old male with a date of industrial injury 7-23-2007. The medical records indicated the injured worker (IW) was treated for cervical intervertebral disc disorder with myelopathy; lumbar intervertebral disc disorder with myelopathy; lumbar fusion; and status post knee arthroscopic surgery. In the progress notes (6-19-15 to 8-21-15), the IW reported multiple painful areas in the cervical and lumbar spine, sacroiliac and pelvic regions and bilateral lower extremities rated 8 out of 10, noticed approximately 70% to 100% of the time. He rated his pain 6 to 7 out of 10 at its best and 8 to 9 out of 10 at its worst. He also reported numbness and tingling in the sacroiliac and pelvic regions and in the buttocks, legs and feet, noticed approximately 70% to 80% of the time. He complained of dizziness, anxiety and stress. Medications and rest improved his symptoms. Many activities of daily living made his symptoms worse, such as walking, standing, bending and dressing. Medications listed were Norco, Prilosec and FCL topical cream. On examination (8-21-15 notes), cervical and lumbar ranges of motion documented were reduced compared to the normal measurements listed. He had palpable tenderness of the "bilaterally medial joint line with crepitus and edema". Ranges of motion of the knees were stated as 75% of normal and were not significantly changed since the previous exam. Treatments included medications and home exercise. The IW was temporarily totally disabled. The plan for treatment included recommendation to a spine specialist, medications and a functional capacity evaluation to determine current work and activities of daily living capacity. A Request for Authorization dated 8-21-15 was received for a functional

capacity evaluation. The Utilization Review on 8-31-15 non-certified the request 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 Evaluation: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Work-Relatedness, Activity, Work.

**Decision rationale:** Pursuant to the ACOEM, functional capacity evaluation is not medically necessary. The guidelines state the examiner is responsible for determining whether the impairment results from functional limitations and to inform the examinee and the 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 examinees tolerance for the activity in question. There is little scientific evidence confirming functional capacity evaluations to 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. The guidelines indicate functional capacity evaluations are recommended to translate medical impairment into functional limitations and determine work capability. Guideline criteria functional capacity evaluations include prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modify job, the patient is close to maximum medical improvement, and clarification any additional secondary conditions. FCEs are not indicated when the sole purpose is to determine the worker's effort for compliance with the worker has returned to work and an ergonomic assessment has not been arranged. In this case, the injured worker's working diagnoses are cervical IVD with myelopathy; lumbar IVD disorder with myelopathy; lumbar fusion status post op; and knee arthroscopic surgery. The date of injury is July 23, 2007. Request for authorization is August 21, 2015. According to an August 21, 2015 progress notes, subjective complaints include the cervical region, lumbar region, sacroiliac, right, pelvic, anterior leg, anterior knee, left but a left lower extremity with pain scores 8/10. The injured worker has notable anxiety and stress. Objectively, there is decreased cervical range of motion, lumbar range of motion. There is decreased range of motion of the left and right knees. The medical record contains detailed degrees with range of motion at the cervical spine lumbar spine right and left knees, and grip strength of the hands. The treatment plan contains a request for orthopedic spine specialist. The treating provider is requesting prior medical records to review MRI of the cervical spine and lumbar spine ordered by a second provider. There is no documentation of prior unsuccessful return to work attempts. There is no documentation the injured worker is close to maximal medical improvement. FCEs are not indicated when the sole purpose is to determine the worker's effort for compliance with the worker has returned to work and an ergonomic assessment has not been arranged. The treating provider is ordering a functional capacity evaluation to determine current work and ADL capacity. There is no clinical rationale in the medical record for FCE. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation of prior unsuccessful return to work attempts, no

documentation the injured worker is close to maximum medical improvement, and documentation the treating provider is requesting prior medical records with MRI scans to evaluate, functional capacity evaluation is not medically necessary.