

<b>Case Number:</b>	CM15-0023301		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	06/11/2012
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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 48-year-old male who reported an injury on 09/27/2012 due to an unspecified mechanism of injury. On 02/03/2015, he presented for a follow-up evaluation regarding his work related injury. He noted that he had pain in the neck and back that was rated a 9/10 the past week prior to the visit, a 7/10 at its best in the last week prior to the visit, and his average a 9/10 in the last week prior to the visit. Associated symptoms included numbness, tingling, spasms, headaches, fatigue, swelling, locking, and weakness. His medications included Norco, Lyrica, and carisoprodol. A physical examination showed tenderness to palpation in the retropatellar on the right and trigger points palpated in the levator scapulae, rhomboid region, and lumbar region on the left, and upper trapezius, lower trapezius, and gluteus medius bilaterally. Range of motion to the lumbar spine was documented as forward flexion to 60 degrees, extension to 10 degrees, lateral bending to the left to 15 degrees and to the right to 15 degrees with pain limited with all planes in the left ankle. Motor strength was noted to be a 4/5 with left ankle dorsiflexion and with right ankle dorsiflexion. Paresthesias were noted with increased sensation and allodynia in the left ankle medial aspect and proximal and distal area. He had a positive SI joint compression test and positive slump test. He was diagnosed with chronic pain syndrome, abnormality of gait, plantar fasciitis, tenosynovitis of the foot and ankle, pes anserinus bursitis, and sciatica. It was recommended that he attend physical therapy to address his issues. The treatment plan was for a functional restoration program, a low post back brace, and Functional Capacity Evaluation. The rationale for treatment was not provided.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Functional Restoration Program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs) Page(s): 30-34.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 30.

**Decision rationale:** The California MTUS Guidelines recommend functional restoration programs for those with conditions that put them at risk for delayed recovery. There should also be evidence that all other appropriate treatment modalities have been tried and failed and there should be documentation of improvement with physical therapy followed by a plateau. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic. However, there was a lack of documentation showing that he has tried and failed all recommended treatment modalities to support the request for a functional restoration program. Without documentation to show that the injured worker is an appropriate candidate for a functional restoration program, the request would not be supported. Furthermore, the number of hours being requested for the functional restoration program was not stated within the request. Therefore, the request is not supported. As such, this request is not medically necessary.

### **Low Post Back Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar supports.

**Decision rationale:** The Official Disability Guidelines recommend lumbar supports for treatment but state that they are not recommended for prevention. The documentation provided failed to show whether the lumbar back brace was being requested as a rental or a purchase. There was also a lack of documentation showing a clear rationale for the medical necessity of its use and whether it is being used for prevention or treatment. Without this information, the request would not be supported by the evidence based guidelines. As such, this request is not medically necessary.

### **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 2nd Ed., Independent Medical Examinations and Consultations Chapter, pages. 137-138.

**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. A clear rationale was not provided for the medical necessity of a Functional Capacity Evaluation. There was no indication that the injured worker meets any of the criteria listed above within the cited guidelines. Without documentation to show that a Functional Capacity Evaluation is medically necessary for the injured worker, the request would not be supported. Therefore, this request is not medically necessary.