

<b>Case Number:</b>	CM15-0030361		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	08/11/2000
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 is a 50 year old female, who sustained an industrial injury on August 11, 2000. She has reported assisting a patient to the bathroom and the patient started to pass out and the injured worker grabbed her from falling and had sudden onset of pain in her low back and it progressively worsened and started traveling down her right leg. The diagnoses have included lumbosacral sprain/strain status postindustrial injury, stat post L5-S1 lumbar laminectomy with post laminectomy syndrome, history of lumbar face syndrome, stats post radiofrequency ablation, lumbar radiculopathy and chronic pain syndrome. Treatment to date has included physical therapy, Magnetic resonance imaging and in October 20033 she had a microdiscectomy, radiofrequency ablation and pain medication. Currently, the injured worker complains of hyperextension low back with recent flare up exacerbation. In a progress note dated January 15, 2015, the treating provider reports examination reveals a slight antalgic gait, moderate to severe tenderness over the lumbar paraspinal muscle and bilateral gluteus, moderate tenderness over the L3-4, L4-5 and L5-S1 and focal tenderness over the bilateral L4-5 and L5-S1 facet joint, decreased range of motion of the lumbar spine and positive straight leg raise test bilaterally. On February 12, 2015 Utilization Review non-certified chronic pain rehab consult, noting, Medical Treatment Utilization Schedule Guidelines was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Chronic Pain Rehab Consult:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration programs.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Functional capacity evaluation (FCE) <http://www.odg-twc.com/>.

**Decision rationale:** According to ODG guidelines, <http://www.odg-twc.com/> Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. See entries for Work conditioning, work hardening in each body-part chapter, for example, the Low Back Chapter. Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. (Lechner, 2002) (Harten, 1998) (Malzahn, 1996) (Tramposh, 1992) (Isernhagen, 1999) (Wyman, 1999) Functional capacity evaluation (FCE), as an objective resource for disability managers, is an invaluable tool in the return to work process. (Lyth, 2001) There are controversial issues such as assessment of endurance and inconsistent or sub-maximum effort. (Schultz-Johnson, 2002) Little to moderate correlation was observed between the self-report and the Isernhagen Work Systems Functional Capacity Evaluation (FCE) measures. (Reneman, 2002) Inconsistencies in subjects' performance across sessions were the greatest source of FCE measurement variability. Overall, however, test-retest reliability was good and interrater reliability was excellent. (Gross, 2002) FCE subtests of lifting were related to RTW and RTW level for people with work-related chronic symptoms. Grip force was not related to RTW. (Matheson, 2002) Scientific evidence on validity and reliability is limited so far. An FCE is time-consuming and cannot be recommended as a routine evaluation. (Rivier, 2001) Isernhagen's Functional Capacity Evaluation (FCE) system has increasingly come into use over the last few years. (Kaiser, 2000) Ten well-known FCE systems are analyzed. All FCE suppliers need to validate and refine their systems. (King, 1998) Compared with patients who gave maximal effort during the FCE, patients who did not exert maximal effort reported significantly more anxiety and self-reported disability, and reported lower expectations for both their FCE performance and for returning to work. There was also a trend for these patients to report more depressive symptomatology. (Kaplan, 1996) Safety reliability was high, indicating that therapists can accurately judge safe lifting methods during FCE. (Smith, 1994) FCE is a burdensome clinical tool in terms of time and cost, so this RCT evaluated the effectiveness of a short-form FCE protocol, and concluded that a short-form FCE appears to reduce time of assessment (43% reduction) while not affecting recovery outcomes when compared to standard FCE administration. Such a protocol may be an efficient option for therapists performing fitness-for-work assessments. (Gross, 2007) Credibility of both the FCE and FCE evaluator is critical. If the evaluate complains of evaluator bias, lack of expertise, or poor professional conduct, the FCE can be considered useless. (Genovese, 2009) Recent research: An RCT compared FCEs using a well-known protocol, the proprietary WorkWell (Isernhagen Work Systems) FCE (Duluth, MN), with functional interviews conducted by specially trained FCE clinicians (collecting self-report

information only, but no measurements). Even though those who had an FCE were found to have higher work capacity than those who were interviewed, it made no difference to the outcome. RTW results were the same whether the injured worker's capability had been assessed using a full two-day FCE, or a much shorter interview by an expert listener. The authors concluded that FCE does not appear to enhance outcomes (improved RTW rates or functional work levels at follow-up) when integrated into the process of occupational rehabilitation. (Gross, 2013)

Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if 1) Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if the sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. (WSIB, 2003)

There is no documentation that the patient developed a pain syndrome out of control requiring a rehabilitation program. There is no documentation of sleep dysfunction and there is no documentation that the pain is not controlled by pain medications. Therefore the request is not medically necessary.