Case Number:	CM15-0031205		
Date Assigned:	02/24/2015	**Date of Injury:**	03/31/2006
Decision Date:	04/07/2015	**UR Denial Date:**	01/21/2015
Priority:	Standard	**Application Received:**	02/19/2015

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 39 year old female, who sustained a work related injury as a tax specialist on 3/31/06 when moving boxes of tax returns, sustaining an injury to the low back. She has reported symptoms of back pain, buttock pain and hip pain rated at 6-7/10. Prior medical history was not documented. The diagnoses have included chronic low back pain syndrome, lumbar herniated disc, lumbar degenerative disc disease, lumbar radiculopathy, and long term use of medications. Treatments to date included rest, physical therapy, lumbar support, cushion donut, diagnostics, and medications. Diagnostics included an Magnetic Resonance Imaging (MRI) that reported small grade 1/5 right disc herniation L5-S1 with mild effacement, epidural fat anterior and medial to the proximal right S1 nerve root, mild midline annular bulging at L4-5. The treating physician's report (PR-2)from 1/19/14 indicated a chronic pain condition with problems to include psychalgia, displacement of lumbar intervertebral disc without myelopathy, degeneration of lumbar sacral intervertebral disc, backache with radiation. There was decreased range in motion in lumbar area, negative seated straight leg raise bilaterally, tender upon palpation along the lumbar paraspinous muscles and gluteal musculature. Mood remained depressed. Due to not being a surgical or injection candidate, a multidisciplinary evaluation was recommended. On 1/21/15, Utilization Review non-certified a One Day Interdisciplinary Pain Management Evaluation, noting the California Medical treatment Utilization Schedule (MTUS) Guidelines, Chronic Pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

One Day Interdisciplinary Pain Management Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-2.

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 evaluee complains of evaluator bias, lack of expertise, or poor professional conduct, the FCE can be considered useless. (Genovese, 2009) (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 is considered for admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. The patient is suffering depression, which limit the patient ability to participate in a multidisciplinary program. There is no documentation that the patient is motivated to attend the program. Therefore, the request is not medically necessary.