

Case Number:	CM14-0161825		
Date Assigned:	10/07/2014	Date of Injury:	01/21/2014
Decision Date:	11/03/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	10/02/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 51 year old female who reported an injury on 01/21/2014 when a large object fell on her head. Her diagnoses include tension headache, partial tear of rotator cuff, rotator cuff strain and sprain, olecranon bursitis, dislocation of knee, and displacement of the cervical and lumbar disc without myelopathy. Her past treatments included six sessions of physical therapy, six sessions of acupuncture, and medications. On 01/21/2014 the injured worker was examined, an x-ray was taken of her right arm, which was negative, and an MRI was taken of the right shoulder, which revealed a torn tendon. On 09/10/2014, the injured worker complained of constant moderate aching back pain aggravated by bending forward and prolonged standing. She also complained of sharp pain in the shoulders, sharp elbow pain, bilateral knee pain more apparent in the right knee and headaches. The physical examination findings showed 3+ spasm and tenderness to the bilateral paraspinal muscle from C2-C7, T1-T5, and L2-S1, axial and shoulder compression tests were both positive. There was also decreased active range of motion in the cervical, thoracic and lumbar spine and shoulder. The injured workers medications included topical cream and Tylenol, dosages and frequencies were not documented. The treatment plan is pending a surgical consultation and medications. A request was received for a Functional capacity evaluation and Lumbar support orthosis (specifically Apollo LSO or equivalent). The rationale for the requests is not clearly stated. The Request for Authorization form was submitted and dated on 08/08/2014.

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 ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.

Decision rationale: The request for functional capacity evaluation is not medically necessary. The California MTUS ACOEM Guidelines state that determining disabilities is not a medical issue and, usually, clinicians are simply being asked to provide an independent assessment of what the patient is currently able and unable to do. However, the guidelines also stated that it may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination which, under some circumstances, can best be done by ordering a functional capacity evaluation. The injured worker reported pain in her back, shoulders and knees and she was noted to have decreased range of motion in the cervical, thoracic and lumbar spine and shoulder. However, there was no documentation indicating the rationale for a functional capacity evaluation with details indicating why a more precise delineation of the injured worker's capabilities is needed. In the absence of this documentation, the request is not supported by the guidelines. Therefore, the request is not medically necessary.

Lumbar support orthosis (specifically Apollo LSO or equivalent): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The request for Lumbar support orthosis (specifically Apollo LSO or equivalent) is not medically necessary. The California MTUS ACOEM Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The injured worker complained of constant moderate aching back pain aggravated by bending forward and prolonged standing. However, as it has been more than 6 months from the time of her injury, she has exceeded the acute phase of symptom relief. Therefore, the request is not supported as the referenced guidelines do not support use of lumbar supports for chronic pain. As such, the request is not medically necessary.