

Case Number:	CM14-0211926		
Date Assigned:	12/24/2014	Date of Injury:	05/28/2014
Decision Date:	02/27/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/17/2014

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. 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

Certification(s)/Specialty: Physical Medicine & Rehabn, Pain Management

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 female patient with the date of injury of May 28, 2014. A Utilization Review dated December 4, 2014 recommended non-certification of retro for FCE DOS: 9/17/14. A Progress Report dated September 17, 2014 identifies Subjective Findings of frequent moderate cervical spine and lumbar spine pain, occasional slight pain of the left wrist and hand, intermittent moderate pain of the left hip, constant moderate to severe headache, frequent slight pain of the left elbow, and frequent moderate pain of the thoracic spine. Objective Findings identify +3 spasm and tenderness to the bilateral paraspinal muscles from C2 to C7, bilateral suboccipital muscles and bilateral upper shoulder muscles. Axial compression test was positive bilaterally for neurological compromise. Distraction test was positive bilaterally. Shoulder depression test was positive bilaterally. +2 spasm and tenderness to the bilateral paraspinal muscles from T1 to T9. +3 spasm and tenderness to the bilateral lumbar paraspinal muscles from L1 to S1 and multifidus. Kemps test was positive bilaterally. Yeomans test was positive bilaterally. There was +2 spasm and tenderness to the left lateral and medial epicondyles. Cozens test was positive on the left. Reverse Cozens test was positive on the left. +2 spasm and tenderness to the left anterior wrist and left posterior extensor tendons. Bracelet test was positive on the left. +3 spasm and tenderness to the left gluteus medius muscle and left tensor fasciae latae muscle. Faberes test was positive on the left. Diagnostic Impression identifies post concussion syndrome, tension headache, cervical disc herniation without myelopathy, thoracic sprain/strain, lumbar sprain/strain, left radiohumeral sprain/strain, left hip sprain/strain, anxiety, and sleep disorder. Treatment Plan identifies functional capacity evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Functional Capacity Evaluation, DOS: 9/17/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty-Functional Capacity Evaluation (FCE)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation

Decision rationale: Regarding request for Retro: Functional Capacity Evaluation, DOS: 9/17/2014, Occupational Medicine Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. In the absence of clarity regarding those issues, the currently requested Retro: Functional Capacity Evaluation, DOS: 9/17/2014 is not medically necessary.