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| <b>Case Number:</b>   | CM14-0217868 |                              |            |
| <b>Date Assigned:</b> | 01/07/2015   | <b>Date of Injury:</b>       | 06/04/2014 |
| <b>Decision Date:</b> | 02/28/2015   | <b>UR Denial Date:</b>       | 12/02/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/29/2014 |

### 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: Family Practice

### 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 39 year old jamitor reported an injury to his right forearm and wrist after striking his forearm on a pallet while bringing it down from overhead on June 4, 2014. Initial diagnoses included superficial abrasions and contusion of the forearm. Initial treatment included modified work and x-rays of the right forearm, which were negative. Ongoing treatment included a non-steroidal anti-inflammatory, a proton pump inhibitor, a muscle relaxant, and anti-epilepsy medications and physical therapy. Neurodiagnostic testing performed 7/31/14 revealed no ulnar neuropathy at the elbow or wrist, and was most consistent with a right dorsal ulnar cutaneous neuropathy. A hand surgeon evaluated the patient on 7/14/14 and concluded that he was not a surgical candidate. On October 20, 2014, the treating physician noted continuing burning sensation in the right forearm down to the wrist and fingers, and numbness in the pinkie and middle fingers. The physical exam revealed tenderness to palpation of the medial distal third of the right forearm. The sensory exam revealed paresthesias in the right 3, 4, and 5 fingers of the right hand and the medial aspect of the distal third of the right forearm. The right hand Jamar grip testing was pain limited. Spurling's test was negative and the right elbow Tinel's test was positive. Diagnoses were dorsal cutaneous neuropathy of the right forearm, chronic pain syndrome, and cubital tunnel syndrome. The physician recommended a functional restoration program (FRP) evaluation for chronic pain as the injured worker had not recovered from the functional effects of his condition, and a functional capacity evaluation (FCE) for baseline testing as the injured worker had a lot of problems with the stress of his ongoing chronic pain. Current work status is modified duty with increased restrictions. A 10/24/14 progress note from

the same provider documents significant and rather inexplicable functional problems including moderate difficulty with sitting and with getting off a chair or the toilet which would not be explained by a unilateral forearm and wrist injury, as well as difficulty with personal care, chores, driving and work. The patient states that his pain moderately to severely interferes with his mood and his ability to enjoy life. On December 2, 2014, Utilization Review non-certified prescriptions for a functional restoration program (FRP) evaluation and functional capacity evaluation (FCE) requested on November 21, 2014. The functional restoration program was non-certified based on the injured worker was currently working and it was unclear what the benefit a functional restoration program would be at this time. It was unclear if the injured worker was a candidate for surgical or will require further intervention. The functional capacity evaluation was non-certified based on the injured worker was already working with restrictions and medications. The California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guide page 51: Functional restoration program (FRP) and the California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guide pages 50-51: Functional improvement measures were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Functional Restoration Program Evaluation: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 51.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs), pages 30-32 Page(s): 30-32.

**Decision rationale:** The MTUS reference cited above states that functional restoration programs are recommended in situations where there is access to programs with proven success rates. Prior to referral an adequate evaluation must be made which includes baseline function testing. Previous treatment methods must have been unsuccessful, and there must be an absence of other treatment options which are likely to cause clinical improvement. The patient should not be a candidate for surgery or other treatments that would be clearly warranted. The patient must exhibit motivation to change and be willing to forgo secondary gain such as disability payments, and negative predictors of success must have been addressed. (Negative predictors of success include a negative outlook about future employment and high levels of psychosocial distress including higher pre-treatment levels of depression.) Total treatment should generally not exceed 20 full-days sessions. Treatment in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. In this case, it appears that the criteria have been met for evaluation for a functional restoration program. The patient has not responded to medications or physical therapy, and is not a surgical candidate. There are no obvious untried treatment options likely to result in clinical improvement. There are no clear negative predictors of success, and there is documentation of ongoing significant functional impairment. Based on the MTUS citation above and on the clinical documentation provided for my review, an evaluation for a functional restoration program IS medically necessary because the patient has ongoing functional impairment, has not responded to treatments prescribed by his current physician, is not a surgical candidate and has no obvious negative predictors of success.

## **Functional Capacity Evaluation (FCE): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Capacity Evaluation (FCE) Page(s): 50-51.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81, Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125. Decision based on Non-MTUS Citation Fitness for Duty Chapter, Functional Capacity Evaluation

**Decision rationale:** The ACOEM citation above states that in order to determine a patient's work limitations, it may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient. The work hardening reference states a criterion for entry into a work hardening program may be the performance of an FCE that shows consistent results with maximal effort, which demonstrate capacities below an employer-verified physical demands analysis. (In other words, an FCE may be required to show that a patient is not physically capable of performing his or her job, and needs a work hardening program.) The ODG reference states that FCEs are recommended prior to admission to a work hardening program, with preference for assessments tailored to a specific task or job. They are not recommended for generic assessments in which the question is whether someone can do any type of job generally. FCEs should be considered when case management is hampered by complex issues such as prior unsuccessful attempts to return to work, or conflicting medical reports on an employee's fitness for a modified job; when timing is appropriate and the worker is at or near maximum medical improvement and all secondary conditions are clarified. An FCE should not be performed if its sole purpose is to determine a worker's effort or compliance, or if the worker has returned to work and an ergonomic assessment has not been arranged. The clinical documentation in this case does not support the performance of an FCE. The patient is working at modified duty, and his ability to perform modified work is not being questioned. He is not nearing maximum medical improvement, and has not been referred to a work hardening program. He HAS been referred for evaluation for a functional restoration program. Such an evaluation automatically includes a functional capacity evaluation. Performing an additional FCE prior to his evaluation for the FRP would be redundant. According to the evidence-based citations above and to the clinical documentation provided for my review, a functional capacity evaluation is not medically necessary. It is not necessary because the performance of an FCE prior to evaluation for a functional restoration program would be redundant, and because none of the other situations in which an additional FCE would be advisable are not present. Based on the clinical documentation provided for my review and on the evidence-based citations above, an FCE is not medically necessary because the patient is nowhere near maximal medical improvement, because she does not appear to have any job for which her capabilities could be tested, and because an FCE is not required to determine a patient's ability to perform activities of daily living.

