

Case Number:	CM15-0116488		
Date Assigned:	06/24/2015	Date of Injury:	04/09/2010
Decision Date:	07/23/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/16/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

The injured worker is a 65-year-old male, who sustained an industrial injury on April 9, 2010, incurring injuries to both knees from repetitive work motions. He had a history of knee injuries with surgical interventions. He underwent arthroscopies of the right and the left knees. Treatment included anti-inflammatory drugs, Magnetic Resonance Imaging, x-rays, physical therapy, pain medications and work restrictions and modifications. Currently, the injured worker complained of bilateral knee pain, difficulty walking that was affecting his activities of daily living. His left knee revealed limited range of motion and patella crepitus. Imaging of both knees revealed tricompartmental osteoarthritis. Other diagnoses included knee tendinitis and bursitis. The treatment plan that was requested for authorization included a functional capacity evaluation and unspecified medication refills.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guideline, page 137-138.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, p. 137-138 Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation.

Decision rationale: Regarding request for functional capacity evaluation, ACOEM 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. Given this, the currently requested functional capacity evaluation is not medically necessary.

Medication refills (unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines various sections, NSAIDs Page(s): 60-80.

Decision rationale: Regarding the request for this medication refills, there is a lack of specificity with regard to the medications, the dosage, or the quantity. From the submitted documentation, the patient is on ibuprofen and hydrocodone. With regard to NSAIDs, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that this medication is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. Given this, the current request is not medically necessary.