

<b>Case Number:</b>	CM15-0119261		
<b>Date Assigned:</b>	06/29/2015	<b>Date of Injury:</b>	05/21/2013
<b>Decision Date:</b>	07/30/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2015

### 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: California, Indiana, New York  
 Certification(s)/Specialty: Internal 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 57 year old male, who sustained an industrial injury on 5/21/13. 5/22 The injured worker has complaints of low back pain with radiation the right hip and right leg, down to the ankle. Examination of the lumbosacral spine reveals increased tone and tenderness about the paralumbar musculature with tenderness at the midline thoraco-lumbar junction and over the level of L5-S1 (sacroiliac) facets and right greater sciatic notch. The documentation noted that there is muscle spasm and positive straight leg raise test on the right. The diagnoses have included lumbar spine sprain/strain with radicular complaints. Treatment to date has included abdominal ultrasound revealed fatty liver; magnetic resonance imaging (MRI) showed 8 millimeter osteophyte complex at L4-L5 and 4 millimeter disc bulge at L3-L4; computerized tomography (CT) scan of the lumbar spine on 11/6/14 showed there was multi-level moderate to severe degenerative disc disease with disk space narrowing, disk height loss and osteophytosis as well as multi-level vacuum phenomena and computerized tomography (CT) scan of the lumbar spine on 1/13/15 showed no evidence of lumbar spine fracture or mal-alignment, 5 millimeter disc bulges at L3-4 and L4-5 which together with mild facet arthropathy result in least mild spinal stenosis and mild to moderate bilateral neuroforaminal narrowing. The request was for functional capacity evaluation.

### 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 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Pages 137-8.

**Decision rationale:** Pursuant to the ACOEM, functional capacity evaluation is not medically necessary. The guidelines state the examiner is responsible for determining whether the impairment results from functional limitations and to inform the examinee and the employer about the examinee's abilities and limitations. The physician should state whether work restrictions are based on limited capacity, risk of harm or subjective examinees tolerance for the activity in question. There is little scientific evidence confirming functional capacity evaluations to predict an individual's actual capacity to perform in the workplace. For these reasons it is problematic to rely solely upon functional capacity evaluation results for determination of current work capabilities and restrictions. The guidelines indicate functional capacity evaluations are recommended to translate medical impairment into functional limitations and determine work capability. Guideline criteria for functional capacity evaluations include prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modify job, the patient is close to maximum medical improvement, and clarification any additional secondary conditions. FCEs are not indicated when the sole purpose is to determine the worker's effort for compliance with the worker has returned to work and an ergonomic assessment has not been arranged. In this case, the injured worker's working diagnosis is lumbar spine sprain strain with radiculopathy. The date of injury is May 21, 2013. Request for authorization is dated May 18, 2015. The most recent progress note is dated April 16 2015. The April 16, 2015 progress note is an initial orthopedic evaluation. The injured worker subjectively has low back pain that radiates to the lower extremities. The treating provider received authorization for an ALIF at the L4 - L5 and L5 - S1 levels. If the injured worker is going to undergo an ALIF at the L4 - L5 and L5 - S1 levels, there is no clinical indication or rationale for a functional capacity evaluation. FCEs are not indicated when the sole purpose is to determine the worker's effort for compliance with the worker has returned to work and an ergonomic assessment has not been arranged. There is little scientific evidence confirming functional capacity evaluations to predict an individual's actual capacity to perform in the workplace. For these reasons it is problematic to rely solely upon functional capacity evaluation results for determination of current work capabilities and restrictions. There is no clinical rationale for a functional capacity evaluation with a pending authorization for ALIF at the L4 - L5 and L5 - S1 levels. Based on the clinical information in the medical record, the peer-reviewed evidence-based guidelines and a pending ALIF, functional capacity evaluation is not medically necessary.