

<b>Case Number:</b>	CM13-0043258		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/16/2012
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	10/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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 claimant is a female with date of injury 10/16/2012. Per qualified medical evaluation, the patient complains of pain in the wrists, worse on the right than on the left. There is pain, numbness and burning. Numbness is rated as 8/10. Symptoms are present constantly and they wake her up at night on a consistent basis and there is no significant relief with medications. On exam right wrist dorsiflexion and palmar flexion are reduced. Phalen and Tinel tests are positive for bilateral wrists. Electrodiagnostic studies of bilateral wrists revealed diminished nerve conduction velocity on the right compared with the relatively less affected left. There are also prolonged distal latencies consistent with demyelinating compressive neuropathy at the wrist and at the level that would be expected consistent with carpal tunnel syndrome. Diagnosis is bilateral carpal tunnel syndrome, right greater than left, moderately severe.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INITIAL FCE (FUNCTIONAL CAPACITY EVALUATION):: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Guidelines for Performing an FCE

**Decision rationale:** According to the Official Disability Guidelines, The criteria for a FCE includes repeated difficulty with returning to work, or when the injured worker is at or near reaching maximum medical improvement. In this case, neither of these criteria are met for the employee to justify a functional capacity evaluation. Although there are other criteria that may warrant the use of a functional capacity evaluation, the employee's diagnoses and status do not apply to these criteria. The request for an initial functional capacity evaluation (FCE) is not medically necessary and appropriate.

**INTERFERENTIAL UNIT FOR BILATERAL WRISTS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TENS,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines an interferential stimulator is not recommended as an isolated treatment, however it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. Additionally, the MTUS guidelines support the use of an interferential stimulator for a one month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. In this case, the request is not for a one month trial and the IF unit is not recommended for use without the trial and document evidence of benefit. The request for an interferential unit for bilateral wrists is not medically necessary and appropriate.