

<b>Case Number:</b>	CM14-0081412		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	03/18/2014
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	05/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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. The expert 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 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/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 applicant is a represented [REDACTED] employee who has filed a claim for knee, shoulder, hip, wrist, hand, and elbow pain reportedly associated with an industrial injury of March 18, 2014. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; a lumbar support; several weeks off of work; and topical agents. In a Utilization Review Report dated May 7, 2014, the claims administrator denied a request for functional capacity evaluation, an interferential unit, and a hot-cold therapy unit. The claims administrator cited non-MTUS ODG Guidelines to deny the hot and cold therapy unit. The claims administrator also invoked the MTUS Chronic Pain Medical Treatment Guidelines to deny the interferential unit and the functional capacity evaluation. In a work status report dated April 7, 2014, the applicant was placed off of work through May 12, 2014. By April 23, 2014 the applicant had transferred care to a new primary treating provider who noted that the applicant had multifocal neck, mid back, low back, wrist, elbow, and knee pain complaints. Topical compounds, including Fluriflex, and TG hot were endorsed, along with naproxen, Prilosec, a lumbar support, an interferential unit, and hot and cold therapy unit. A functional capacity evaluation was sought. The applicant was placed off of work, on total temporary disability, through May 28, 2014.

### 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 Chronic Pain Treatment Guidelines Page(s): 48.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21.

**Decision rationale:** While the MTUS Guideline in ACOEM Chapter 2, page 21 does note that functional capacity evaluations could be considered when necessary to translate medical impairment into limitations and restrictions, in this case, the applicant was off of work, on total temporary disability. The applicant was still pending numerous treatments for his various multifocal pain complaints. There is no evidence that the applicant was approaching maximum medical improvement and/or that the applicant needed a functional capacity evaluation to try and translate his impairment into limitations and/or restrictions. It is further noted that the applicant may or may not have a job to return to. For all of the stated reasons, then, the functional capacity evaluation is not medically necessary.

**Interferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117 to 121.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 12, page 300, insufficient evidence exist to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. No applicant-specific rationale or medical evidence was attached to the request for authorization so as to offset the tepid-to-unfavorable ACOEM position on the same. Therefore, the request is not medically necessary.

**Hot/Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee; and ODG Shoulder Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table12-5 and page 299.

**Decision rationale:** As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 12, Table 12-5, at-home local applications of heat and cold are "recommended" as methods of symptom control for low back pain complaints, as were present here. No rationale or medical evidence was furnished so as to offset the unfavorable ACOEM position on the requested Hot/cold therapy unit; therefore, the request is not medically necessary.

