

<b>Case Number:</b>	CM15-0145149		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	09/03/2014
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	07/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: Emergency 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 45 year old female, who sustained an industrial injury on 9-3-14. She has reported initial complaints of pain in the neck, left shoulder and hands due to repetition at work. The diagnoses have included carpal tunnel syndrome, cervical degenerative disc disease (DDD), upper limb region somatic dysfunction and cervicgia. Treatment to date has included medications, activity modifications, diagnostics, occupational therapy, epidural steroid injection (ESI), physical therapy and home exercise program (HEP). Currently, as per the physician progress note dated 7-13-15, the injured worker complains of neck and arm pains with complaints of headaches, neck stiffness, worsened upper extremity pain and paresthesias. She also reports sleep disturbance due to pain. The physical exam reveals that palpation of the right forearm reveals tenderness to palpation. The left upper extremity exam reveals that palpation of the left forearm reveals tenderness. There are no previous diagnostic reports noted. The previous therapy sessions were noted. The work status is modified with restrictions. The physician requested treatments included Comprehensive Functional Capacity Evaluation, Work Hardening (unknown frequency/duration) and Physical Therapy, three times a week for three weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Comprehensive Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine's Occupational Medicine (ACOEM) Practice Guidelines, 2nd Edition (2004) Chapter 7, page 137-138.

**Decision rationale:** The requested Comprehensive Functional Capacity Evaluation is not medically necessary. CA MTUS the American College of Occupational and Environmental Medicine's Occupational Medicine (ACOEM) Practice Guidelines, 2nd Edition (2004) Chapter 7, page 137-138 note in regards to functional capacity evaluations, that "There is little scientific evidence confirming FCEs predict an individual's actual capacity to perform in the workplace." The injured worker has neck and arm pains with complaints of headaches, neck stiffness, worsened upper extremity pain and paresthesias. She also reports sleep disturbance due to pain. The physical exam reveals that palpation of the right forearm reveals tenderness to palpation. The left upper extremity exam reveals that palpation of the left forearm reveals tenderness. There is no documentation that the patient is at Maximum Medical Improvement. The treating physician has not documented the medical necessity for this evaluation as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met, Comprehensive Functional Capacity Evaluation is not medically necessary.

**Work Hardening (unknown frequency/duration):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work Hardening.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning and Work Hardening Page(s): 125-126.

**Decision rationale:** The requested Work Hardening (unknown frequency/duration) is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Work Conditioning and Work Hardening, Pages 125-126; recommend work hardening only with satisfaction of multiple criteria, including: a specific return to work goal, specific job demands, documented on-the-job training, evaluation of possible psychological limitations, be less than two years post-injury, treatment not to be longer than one to two weeks without evidence of patient compliance and demonstrated significant gains. The injured worker has neck and arm pains with complaints of headaches, neck stiffness, worsened upper extremity pain and paresthesias. She also reports sleep disturbance due to pain. The physical exam reveals that palpation of the right forearm reveals tenderness to palpation. The left upper extremity exam reveals that palpation of the left forearm reveals tenderness. The treating physician has not documented a specific return to work goal, specific job demands, documented on-the-job training, nor evaluation of possible psychological limitations. The criteria noted above not having been met, Work Hardening (unknown frequency/duration) is not medically necessary.

**Physical Therapy, three times a week for three weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Active Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The requested Physical Therapy, three times a week for three weeks, is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has neck and arm pains with complaints of headaches, neck stiffness, worsened upper extremity pain and paresthesias. She also reports sleep disturbance due to pain. The physical exam reveals that palpation of the right forearm reveals tenderness to palpation. The left upper extremity exam reveals that palpation of the left forearm reveals tenderness. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor is the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. Therapy, three times a week for three weeks is not medically necessary.