

<b>Case Number:</b>	CM15-0037653		
<b>Date Assigned:</b>	03/06/2015	<b>Date of Injury:</b>	04/18/2014
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/02/2015

### 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

### 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 55 year old, female patient, who sustained an industrial injury on 04/18/2014. A chiropractic visit dated 01/22/2015, reported the patient having gone through extensive conservative care treating her upper back including physical manipulation, acupuncture, injections and prescribed medications. She was referred to undergo extracorporeal shockwave therapy. A request was made for a hot/cold therapy unit to bilateral wrist/hand and an evaluation with a specialist. A primary treating office visit dated 02/05/2015, reported subjective complaint of frequent, mild thoracic back pain, mild left shoulder pain, activity-dependent moderate pain and moderate right wrist pain. Objective findings showed thoracic spine ranges of motion noted painful. There is tenderness to palpation of the thoracic paravertebral muscles. There is also spasm of the thoracic paravertebral muscles. She is also found with tenderness to palpation of the anterior/posterior shoulder. Left wrist range of motion is decreased, painful. The following diagnoses are applied; thoracic sprain/strain; left shoulder bursitis; right wrist myofasciitis; left wrist internal derangement and rule out carpal tunnel syndrome on left. On 02/13/2015, Utilization Review, non-certified the request, noting the CA MTUS/ACOEM, ODG, Low Back Chapter 12, Functional Capacity Eval were cited. On 03/02/2015, the injured worker submitted an application for independent medical review of requested services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional capacity evaluation (FCE): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 48-49.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines, Chapter 7, p137-139 has the following regarding functional capacity evaluations.

**Decision rationale:** The most recent report provided is by [REDACTED] and is dated 02/05/15. It states that the patient presents with bilateral wrist pain. The current request is for functional capacity evaluation (FCE). The RFA is not included. The 02/13/15 utilization review states the request was received 02/06/15. The report states the patient is to return to modified duty 02/05/15. ACOEM Guidelines Chapter 7 page 137 states, "The examiner is responsible for determining whether the impairment results in functional limitations. The employer or claim administrator may request functional ability evaluations. These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace." The treator does not discuss this request. The 02/05/15 Treatment plan only states, "Refer: FCE and Hand specialist." In this case, there is no explanation in the reports provided as to why this evaluation is crucial. There is no evidence that the claims administrator or employer has requested this examination or that the patient desires a return to work and the employer or treating physician is concerned about her ability to do so. FCE's cannot predict a patient's actual capacity in the work place. The request IS NOT medically necessary.

**Hold/cold therapy unit to bilateral Wrists/hand: 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 Knee chapter, Hot Cold packs Knee Chapter, Continuous flow-cryotherapy.

**Decision rationale:** The most recent report provided is by A, DC, and is dated 02/05/15. It states that the patient presents with bilateral wrist pain. The current request is for hold/cold therapy unit to bilateral wrist/hand. Presumably, this request is for a Hot/Cold therapy unit. The RFA is not included. The 02/13/15 utilization review states the request was received 02/06/15. The report states the patient is to return to modified duty 02/05/15. MTUS is silent on hot/cold therapy units. ODG, Forearm, Hand and Wrist Chapter, does not discuss hot/cold therapy units or Cold/heat packs or continuous flow cryotherapy. However, ODG does provide some guidance in the Knee chapter, Hot Cold packs, which recommends ice massage and cold packs; however, hot packs had no beneficial effect on edema. Knee Chapter, Continuous flow-

cryotherapy, states this is recommended as an option after surgery up to 7 days, but not for non-surgical treatment. The treater does not discuss this request. The most recently report provided from 02/05/15 only states the patient is to be referred to a Hand specialist. In this case, the request for a "unit" does not suggest hot/cold packs. Continuous flow-cryotherapy is recommended only for post-surgical use and there is no evidence provided the patient is s/p bilateral wrist/hand surgery. The request is for an indeterminate period of time and guidelines limit post-surgical use to 7 days. Furthermore, guidelines provide no recommendation for Hot/Cold units for the wrist/hand. The request IS NOT medically necessary.