

<b>Case Number:</b>	CM14-0002677		
<b>Date Assigned:</b>	04/04/2014	<b>Date of Injury:</b>	07/23/2007
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	12/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 patient is a 58 year old female who was injured on 09/12/2013. The mechanism of injury is unknown. Her diagnoses are complex regional pain syndrome Type I, and s/p cervical neck surgery. Prior treatment history has included the patient undergoing laminectomy and fusion C3-7 on 02/27/2009. Several stellate blocks which helped followed by physical therapy which has helped improve. The patient has completed physical therapy. The patient's medications include, Vicodin ES , Soma, Ambien, and Cymbalta 60 mg daily. Diagnostic studies reviewed include urine toxicology of unknown dates positive for alcohol metabolites. No other diagnostic tests submitted for review. Progress note dated 09/12/2013 documented the patient to be alert and oriented times 3 and in no acute distress. Language is fluent and patient is able to give clear and coherent history. Objective findings on exam included skin are intact, slight swelling. There is a slight atrophy of the hands intrinsic with weakness of the thumb abduction and finger adduction/abduction as well as wrist extension. Sensory is decreased left C6 distribution of left arm and left hand. DTRs 2/5 symmetrical throughout. There is a well healed post surgical scar on the neck. The treating provider has requested occupational therapy 2 times a week for 6 weeks for the left upper extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OCCUPATIONAL THERAPY (2) TIMES A WEEK FOR (6) WEEKS FOR LEFT UPPER EXTREMITY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** The ODG recommends a trial of 6 sessions in conjunction with an active HEP. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical/occupational therapy). The medical records documents there are no records reporting any objective functional improvement from any previous PT/OT. There was no specific documentation of any functional improvement with previous therapy services. Medical necessity for the 12 sessions of OT has not been established. Therefore the requested is not medically necessary.