

<b>Case Number:</b>	CM14-0011692		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	12/10/2008
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 injured worker is a 59-year-old female who reported an injury on 12/10/2008. Current diagnoses include complex regional pain syndrome type 2 and neuropraxia. The latest Physician Progress Report submitted for this review is documented on 06/12/2013. The injured worker reported moderate achy pain. Previous conservative treatment includes stellate ganglion blocks and physical therapy. The injured worker also underwent right carpal tunnel release on 07/24/2009. Physical examination revealed decreased range of motion with tenderness to palpation of the right shoulder, tenderness to palpation of the right wrist, and normal range of motion of the right wrist. Treatment recommendations included 6 sessions of physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **OCCUPATIONAL THERAPY 2XWK X 3 WEEKS RIGHT HAND: 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, HAND WRIST AND FOREARM DISORDERS,

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

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. As per the documentation submitted, the injured worker has previously participated in occupational therapy. However, there is no evidence of objective functional improvement that would warrant the need for additional treatment. The injured worker also demonstrates normal range of motion without tenderness, effusion, or crepitus in the right wrist. Documentation of a significant musculoskeletal or neurological deficit that would warrant the need for skilled physical medicine treatment was not provided. Based on the clinical information received and the California MTUS Guidelines, the request of six (6) occupational therapy sessions for right hand is not medically necessary and appropriate.