

<b>Case Number:</b>	CM14-0128403		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	01/17/2011
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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 Anesthesiology, has a subspecialty in Pain 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 60 year old female whose date of injury is 01/17/2011. The mechanism of injury is described as lifting a box of cat litter. Treatment to date includes right wrist surgery in 2012, injection therapy and medication management. EMG/NCV (Electromyography / Nerve Conduction Velocity) dated 04/01/14 revealed evidence of mild to moderate right wrist median neuropathy at the carpal tunnel region. Note dated 07/24/14 indicates that the injured worker complains of right carpal tunnel overuse syndrome. On physical examination, there is middle finger paresthesia. Grip strength is 20/25/23 on the right and 40/55/50 on the left.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Three (3)Occupational Therapy (OT) Sessions to Right Wrist: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

**Decision rationale:** Based on the clinical information provided, the request for 3 occupational therapy sessions to right wrist is not recommended as medically necessary. The submitted records indicate that the injured worker has been recommended for occupational therapy to

arrange home compression device for night usage. There is no support for home compression device in the current evidence based guidelines, and therefore, medical necessity for 3 visits of occupational therapy is not established. Additionally, there are no specific, time-limited treatment goals provided. Therefore, the request of three (3) Occupational Therapy (OT) Sessions to Right Wrist is not medically necessary and appropriate.