

<b>Case Number:</b>	CM14-0201510		
<b>Date Assigned:</b>	12/11/2014	<b>Date of Injury:</b>	02/03/2011
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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. 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: New York  
 Certification(s)/Specialty: Internal 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 40 year old female, who sustained an industrial injury on February 3, 2011. She has reported wrist injury. The diagnoses have included wrist sprain, tendonitis, and compression neuropathy. Treatment to date has included 18 completed post-operative occupational and physical therapy sessions, surgery, and rest. Currently, the IW complains of recurring pain in the right forearm. Physical findings are noted as tenderness of the brachioradialis muscle and radial tunnel. A well healed surgical scar is noted over the radial tunnel. On November 7, 2014, Utilization Review non-certified occupational therapy, two times weekly for four weeks, for the right wrist, based on MTUS, Chronic Pain Medical Treatment guidelines. On November 24, 2014, the injured worker submitted an application for IMR for review of occupational therapy, two times weekly for four weeks, for the right wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational therapy for the right wrist, twice a week for four weeks:** Upheld

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

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

**Decision rationale:** Per California MTUS Treatment Guidelines 2009, physical medicine ( PT/OT) is indicated for the treatment of chronic pain conditions. Recommendations state that for most patients with pain conditions therapy is indicated as long as functional improvement and program progression are documented. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices in this case the claimant completed 18 sessions of post-operative physical and occupational therapy. The claimant is 9 months post-procedure and has no documented loss of function. There is no specific indication for additional occupational therapy sessions. Medical necessity for the requested occupational therapy sessions (8) has not been established. The requested service is not medically necessary.