

<b>Case Number:</b>	CM15-0002197		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	01/08/2002
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	01/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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: Family Practice

### 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 who reported injury on 01/08/2002. The mechanism of injury was not provided. The documentation of 09/03/2014 revealed the injured worker had diagnoses including bilateral upper extremity repetitive strain injuries with upper extremity cumulative trauma and shoulder tendinitis and impingement. The request was made for bilateral wrist braces, massage, acupuncture, and an ergonomic evaluation to try different keyboards. The injured worker's medications were noted to include Flexeril, Lidoderm patches, and Voltaren gel. The injured worker was noted to have pain in the bilateral hands and wrists, worse on the left than the right. The injured worker was noted to have a need for massage, and it was indicated the injured worker could not use medications due to GI upset and gastrointestinal bleeding. The injured worker was noted to have tenderness in the upper neck and back and was guarding shoulder abduction. The treatment plan included an ergonomic evaluation. There was no Request for Authorization submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ergonomic Evaluation to evaluate home and work station:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Forearm, Wrist, & Hand, Ergonomic Interventions

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 266.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that careful ergonomic re-analysis of the job is indicated if the individual fails to improve. The clinical documentation submitted for review indicated the injured worker was failing to improve. However, there was a lack of documentation indicating a necessity for both a work station and a home environment ergonomic evaluation. Given the above, the request for Ergonomic Evaluation to evaluate home and work station is not medically necessary.