

<b>Case Number:</b>	CM15-0105156		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	11/03/2014
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### 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 25 year old female, who sustained an industrial injury on 11/3/14. The injured worker was diagnosed as having tendinitis of left wrist, tendinitis of left elbow, left wrist joint pain and left elbow joint pain. Treatment to date has included wrist brace, physical therapy, occupational therapy, H-wave, activity restrictions and Tylenol. Currently, the injured worker complains of sharp pain over left wrist and difficulty opening bottles. She is using the H-wave for pain and no medications; she feels the H-wave is working. She may work on modified duty if available. Physical exam noted full range of motion of wrist, hand and elbow and tenderness of left first dorsal wrist compartment. A request for authorization was submitted for 6 additional occupational therapy visits for left wrist with home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Occupational Therapy, 2 times wkly for 3 wks, Left Wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): table 11-7, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines: Carpal tunnel syndrome.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional occupational therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior OT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested additional occupational therapy is not medically necessary.