

<b>Case Number:</b>	CM15-0160043		
<b>Date Assigned:</b>	08/26/2015	<b>Date of Injury:</b>	09/14/2010
<b>Decision Date:</b>	09/29/2015	<b>UR Denial Date:</b>	07/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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: Massachusetts

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 62 year old male, who sustained an industrial injury on 9-14-2010. He reported left knee and right wrist pain. Diagnoses have included left knee arthritis, right cubital tunnel syndrome, right wrist sprain-strain, right carpal tunnel syndrome and left medial meniscus tear. Treatment to date has included magnetic resonance imaging (MRI), surgery, therapy and medication. According to the progress report dated 6-29-2015, the injured worker complained of right elbow pain, right hand-wrist pain and left knee-leg pain. Current medications included Anaprox, Nifedipine and Prilosec. Exam of the right hand-wrist revealed tenderness to palpation on the medial aspect of the thumb. Range of motion was limited secondary to pain. Authorization was requested for occupational therapy 2 times a week for 4 weeks for right hand-wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational therapy 2 times a week for 4 weeks for right hand/wrist, per 6/29/15 order:**  
Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work-related injury in September 2010 and is being treated for left knee and right elbow, wrist, and hand pain. He underwent an ulnar nerve release in May 2013. When seen, there was thumb tenderness and decreased range of motion. An x-ray of the wrist and hand was negative for arthritic changes. Occupational therapy was requested. The claimant is being treated for chronic pain with no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to determine whether continuation of therapy was likely to be effective. The request was not medically necessary.