

<b>Case Number:</b>	CM15-0205296		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	04/20/2012
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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: North Carolina

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 29 year old female with a date of injury on 04-20-2012. The injured worker is undergoing treatment for chronic pain syndrome with a history of complex regional pain syndrome. She has a history of anxiety, asthma, depression and frequent headaches. A physician progress note dated 09-09-2015 documents the injured worker has complaints of left wrist and hand pain that has been going on for many years. She has severe constant chronic pain. Her pain is described as achy with abnormal temperature and sensation in the arm and the left wrist and hand that is not new. On examination she has touch allodynia and guarded use of the left hand with a little bit of intrinsic hand muscle atrophy. There is documentation present that the injured worker has received therapy in the past but the amount and results of the therapy are not documented. Treatment to date has included diagnostic studies, medications; status post left wrist arthroscopy with repair of triangulofibrocartilage complex and ganglionectomy, psychology, psychiatry, and Functional Rehabilitative Program, and therapy. Current medications include Cymbalta and Lyrica. The Request for Authorization includes refilling her prescriptions of Cymbalta and Lyrica and a prescription for OT 3 times a week for 6 weeks. On 09-21-2015 Utilization Review non-certified the request for Occupational Therapy three times a week for six weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational Therapy three times a week for six weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2). 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.