

<b>Case Number:</b>	CM15-0027049		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	02/01/2013
<b>Decision Date:</b>	04/21/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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

### 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 53-year-old female with an industrial injury dated February 1, 2013. The injured worker diagnoses include right shoulder rotator cuff tendinitis/bursitis/impingement, Right de Quervain tendinitis, right flexor carpi radialis tendinitis, bilateral base of thumb arthritis, right wrist occult ganglion cyst and possible right greater than left carpal tunnel syndrome. She has been treated with diagnostic studies, prescribed medications, therapy and bracing for wrist, consultation and periodic follow up visits. According to the most recent medical evaluation dated 7/16/2014, the injured worker reported right shoulder pain, right wrist area pain, occasional right finger numbness and left wrist pain. Right shoulder exam revealed tenderness, slight loss of motion, pain with range of motion, and positive impingement sign. Right wrist and hand revealed tenderness, painful motion at base of the thumb, painful grip test, positive grind test and positive Finkelstein test. The treatment plan was further evaluation and physician supervised medical care. There was no current physician progress notes submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational Therapy 3x4 weeks right hand:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** This patient has a date of injury of 02/01/2013 and presents with chronic upper extremity pain with tightness, tingling, and weakness noted. Patient has a diagnosis of reflex sympathetic dystrophy of the upper limb. The medical file provided for review does not include a Request for Authorization form. The current request is for occupational therapy 3 times a week for 4 weeks, right hand. For physical medicine, the MTUS guidelines pages 98 and 99 recommends for myalgia, myositis, and neuritis-type symptoms 9 to 10 sessions over 8 weeks. This patient presents with continued hand pain with numbness and tingling. The medical file provided for review does not include any physical therapy reports and only includes one progress report dated 01/16/2014 that provides no discussion regarding treatment history. The utilization review states that the patient has had physical therapy in the past. In this case, the request for 12 occupational therapy sessions exceeds what is recommended by MTUS. This request is not medically necessary.

**Right shoulder surgery consult:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Independent Medical Examinations and Consultations, Chapter 7, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch: 7 page 127.

**Decision rationale:** This patient has a date of injury of 02/01/2013 and continues to complain of upper extremity pain with tightness, tingling, and weakness noted. The patient has a diagnosis of reflex sympathetic dystrophy of the upper limb. The medical file provided for review does not include a Request for Authorization form. The current request is for a right shoulder consult. The American College of Occupational and Environmental Medicine, ACOEM, second edition 2004 chapter 7, page 127 states that "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss, and/or the examinees fitness for return to work." The patient rates her right shoulder pain as 8/10 on the pain scale and describes the pain as aching, burning, dull, numb, sharp, spasm, throbbing, tightness, with tingling and weakness. Patient reports that her activities of daily living are limited by about 80% due to continued pain. In this case, a referral to a specialist for consultation is in accordance with ACOEM guidelines. This request is medically necessary.