

<b>Case Number:</b>	CM14-0149743		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	09/19/2006
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2014

### 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. The expert reviewer is Board Certified in Geriatrics and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 56 year old woman with a date of injury of 9/19/06. She was seen by her hand surgeon / physician on 8/1/14 to follow up right and left carpal tunnel release, left hand wrist fracture with chronic wrist pain status post arthroscopy, debridement and synovectomy in 2007 and 2008. She had complaints of pain in her left wrist with numbness, burning and itchiness of her left hand and fingers. Her exam showed a positive median nerve compression test and Tinel's sign. She had decreased sensation in her ulnar > medial distribution of her left hand. At issue in this review is the request for occupational therapy twice weekly for 4 weeks for range of motion to her left upper extremity and hands.

### 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: Upheld**

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

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

**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. In this

injured worker, her injury was from 2006 and she is status post-surgical interventions in the past. The records do not document that she has a reduction in range of motion of her upper extremity or that occupational therapy to the upper extremity focusing on range of motion will positively impact her pain or function. The records do not support the medical necessity for occupational therapy visits in this injured worker with chronic left wrist pain.