

<b>Case Number:</b>	CM14-0165342		
<b>Date Assigned:</b>	10/10/2014	<b>Date of Injury:</b>	04/10/2014
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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 Physical Medicine & Rehabilitation, and is licensed to practice in Texas. 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:

Medical records reflect the claimant is a 47 year old male who sustained a work injury on 4-10-14. Office visit on 9-2-14 notes the claimant has a history of tingling to the right forearm and pain at the right thenar eminence. The claimant reports that physical therapy has helped and she will finisher her last two weeks completing 12/12. On exam, the claimant has tenderness to palpation at the right volar thenar eminence, full range of motion. Positive cubital Tinel's along the ulnar distribution. She has full range of motion. Manual muscle testing is 5/5. Sensory exam is intact.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational/Hand Therapy QTY: 8:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand (Acute & Chronic); Physical Therapy

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus

active self-directed home Physical Medicine. The claimant had been provided 12 physical therapy sessions. There is an absence in documentation noting that this claimant cannot perform a home exercise program. There are no extenuating circumstances to support physical therapy at this juncture. Per the records provided, this claimant should already be exceeding well-versed in an exercise program. It is not established that a return to supervised physical therapy is medically necessary and likely to significantly improve or impact the patient's overall pain level and functional status beyond that of her actively utilizing an independent home exercise program. The guidelines state patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Therefore, the medical necessity of the request is not established.