

<b>Case Number:</b>	CM15-0111946		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	04/02/2012
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 43-year-old female, who sustained an industrial/work injury on 4/2/12. She reported initial complaints of pain in wrists and right shoulder. The injured worker was diagnosed as having carpal tunnel syndrome bilateral upper extremities, impingement syndrome of right shoulder, repetitive strain injury, bilateral wrists, lateral epicondylitis of right elbow, and rule out cervical radiculopathy at C6-7. Treatment to date has included medication, diagnostics, surgery ( right shoulder arthroscopic surgery), left wrist injection, and psychiatric treatment. MRI results were reported on 9/6/12 that reported fraying of the bursal surface and subdeltoid bursitis and focal partial tear anterior leading edge articular surface insertion. Currently, the injured worker complains of increased wrist pain bilaterally, (R>L) without numbness and tingling. Per the treating physician's report on 5/11/15, examination revealed mild tenderness at the radial tunnel bilaterally, no wrist tenderness, full range of motion in all digits both hands, wrists, and elbows, Tinel's negative, and negative at the median/ulnar nerves of both wrists and ulnar nerve of both elbows. Current plan of care included NSAIDS (non-steroid anti-inflammatory medication), ice, heat as needed, occupational therapy, and ergonomic modifications. The requested treatments include occupational therapy, bilateral upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational Therapy, Bilateral Upper Extremities, Qty 12: Upheld**

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

**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 injury in April 2012 and continues to be treated for upper extremity pain. When seen, she was having increasing wrist pain. She was not having any numbness or tingling. Physical examination findings included mild radial tunnel tenderness. There was an otherwise normal examination. Recommendations included use of bracing at night, medications, heat, ice, and she was referred for occupational therapy treatments. The claimant is being treated for chronic pain. There is no new injury or acute exacerbation. 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 would be expected to reestablish or revise a home exercise program. The request is not medically necessary.