

<b>Case Number:</b>	CM15-0066710		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	02/01/2012
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal Medicine

### 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 female, who sustained an industrial injury on February 1, 2012. The injured worker was diagnosed as having status post right sided fall on an outstretched hand, right chronic regional pain syndrome II, right greater than left carpal tunnel neuropathy median nerve, right greater than left neuropathy ulnar nerve Guyon's canal and cubital tunnel, right greater than left chronic bilateral wrist pain, right de Quervain's disease status post cortisone injection on November 9, 2012, right lateral epicondylitis status post cortisone injection on October 12, 2012, right volar radial wrist ganglion cyst, right dorsal wrist ganglion cyst, left de Quervain's disease, and left lateral epicondylitis. Treatment to date has included cortisone injections, bone scan, electromyography (EMG)/nerve conduction study (NCS), x-rays, physical therapy, and medication. Currently, the injured worker complains of weakness, swelling, and electrical sensation of both hands, dropping objects with both hands, pain radiating from the right hand up the arm up to the neck and back, stiffness of the right arm, swelling of the ankles and knees, pressure sensation on the top of the head, pain radiating from the left hand to the elbow, bruising of both forearms, and sensitivity of the right and left hands (thenar eminence). The Treating Physician's report dated March 6, 2015, noted the physical examination of the right and left upper extremities was noted to be unchanged. The treatment recommendations included occupational therapy, second opinion consult by pain management specialist, and medications including Lunesta, Tramadol, Anaprox, and Prilosec.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational Therapy: 1 time per week (unspecified amount of weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical / Occupational Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand Section, Physical Therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, occupational therapy one time per week (unspecified number of weeks) is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are right chronic regional pain syndrome II, right and left carpal tunnel syndrome; right and left neuropathy ulnar nerve Guyon's canal and cubital tunnel; chronic bilateral wrist pain; right DeQuervain's disease status post cortisone injection; right lateral epicondylitis; right volar radial wrist ganglion cyst; right dorsal wrist ganglion cyst; left DeQuervain's disease; and left lateral epicondylitis. The documentation does not contain evidence of objective functional improvement from an unknown number of prior physical therapy sessions to date. A March 6, 2015 progress note states the purpose of physical therapy is to prevent further contractures. The treatment plan indicates one session of physical therapy per week times six weeks is requested. The injured worker should be well-versed in the exercises performed at physical therapy to engage in a home exercise program. Again, the injured worker has participated in an unknown number of physical therapy sessions. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. There are no compelling clinical facts in the medical record indicating additional physical therapy is warranted. Consequently, absent compelling clinical documentation with objective functional improvement (of prior physical therapy) and compelling clinical facts indicating additional physical therapy is warranted, occupational therapy one time per week (unspecified number of weeks) is not medically necessary.