

<b>Case Number:</b>	CM14-0148283		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	02/10/2004
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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 Illinois. 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 47-year-old female with a reported injury on 02/10/2004. The mechanism of injury was not reported. The injured worker's past treatments included medications, physical therapy, injections, and a wrist splint. The injured worker's diagnostic testing included a left shoulder MRI on 12/02/2013 and an MRI of the right wrist in 08/2005 which showed changes in the lunate bone typical of ulnar impaction syndrome. The injured worker's surgical history included a left lateral epicondylar debridement on 03/03/2005. The injured worker was evaluated on 07/09/2014 for right wrist pain with tenderness and pins and needles. The clinician observed and reported that the right wrist was diffusely tender with no swelling. Tenderness was localized to the volar aspect of the flexor surface. Carpal compression test was negative, grip strength was weak, and no atrophy of the thenar or hypothenar eminences was noted. The injured worker was subsequently seen on 07/15/2014 and 07/22/2014. On those visits, the clinician reported that the patient was to continue a home exercise program and the TENS unit. On 07/22/2014, the clinician observed and reported bilateral wrist pain with range of motion. The injured worker's medications included Cyclobenzaprine and Omeprazole. The request was for occupational therapy 2 times per week times 4 weeks. The rationale for the request was for pain in joint, upper arm, and carpal tunnel syndrome. The request for authorization form was submitted on 07/09/2014.

### 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 x 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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

**Decision rationale:** The request for occupational therapy 2 times a week x 4 weeks is not medically necessary. The injured worker continued to complain of right wrist pain. The California MTUS Chronic Pain Guidelines do recommended active therapy for restoring flexibility, strength, endurance, function, range of motion, and to alleviate discomfort. The injured worker was documented to be doing a home exercise program. No documentation of functional deficit was provided. Therefore, the request for occupational therapy 2 times a week x 4 weeks is not medically necessary.