
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/23/2013
Date of Injury: 10/5/2012
IMR Application Received: 8/19/2013
MAXIMUS Case Number: CM13-0013216

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in physical medicine and rehabilitation and is licensed to practice in Oklahoma and 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 42-year-old who reported injury on 10/05/2012. The patient was initially seen in the emergency room on 10/08/2012 with complaints of right wrist pain radiating to her elbow secondary to cleaning duties at work. The patient was seen for initial physical therapy evaluation on 10/15/2012. The patient received therapy through at least 03/2013. Physical therapy progress note on 03/05/2013 reported the patient had benefited from exercise and was discharged to a home exercise program after completing 20 visits. A recent evaluation on 06/26/2013 reported the patient had complaints of pain at the right elbow, right wrist, right hand, low back, and bilateral hips. On physical examination the patient had 0 degrees to 140 degrees of right elbow range of motion, which was reported as normal. The patient also had reported normal right wrist range of motion. The patient had 70 degrees of lumbar flexion and 31 degrees of extension. The patient has been recommended for 18 physical therapy sessions and has current diagnosis of rule out right carpal/cubital tunnel syndrome, right medial epicondylitis, rule out internal derangement right wrist, rule out lumbar radiculopathy, and lumbar spine strain.

IMR DECISION(S) AND RATIONALE(S)

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

1. Physical therapy three times per week for 6 weeks; right elbow, wrist, and lumbar spine, is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 99, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 98 - 99, which is part of the MTUS.

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines recommend up to 10 sessions of physical therapy for the diagnoses of myalgia, myositis, neuralgia, neuritis, and/or radiculitis. The documentation submitted for review indicates the patient has participated in 20 prior sessions of physical therapy to date. Therefore, the request for 18 additional sessions of physical therapy would exceed evidence-based guidelines for total duration of care. Furthermore, the clinical evaluation on 06/26/2013 failed to reveal any significant functional deficits associated with the right elbow, right wrist, and/or lumbar spine to warrant formal physical therapy services at this time. Given the lack of functional deficits and excessive nature of the request, the request for physical therapy 3 times a week for 6 weeks for the right elbow, right wrist, and lumbar spine is non-certified.

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

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