

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/6/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/15/013
Date of Injury:	3/30/2011
IMR Application Received:	8/28/2013
MAXIMUS Case Number:	CM13-0017580

- 1) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 2 times a week for 6 weeks to the bilateral wrists** is not medically necessary and appropriate.

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/28/2013 disputing the Utilization Review Denial dated 8/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made. for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 2 times a week for 6 weeks to the bilateral wrists is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

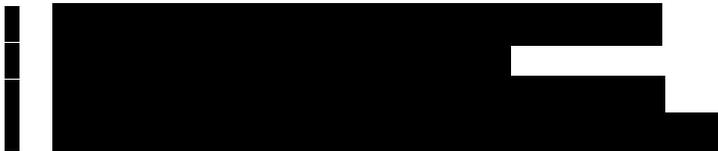
The independent Medical Doctor who made. the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and Neuromuscular Medicine and is licensed to practice in California. He/she has 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

Claimant is a 44 year old female who reported sustaining a work related injury to the bilateral upper extremities on 3/30/11 due to repetitive motion. She was diagnosed with an elbow strain and bilateral carpal tunnel syndrome. Eventually she underwent bilateral carpal tunnel release on an unspecified date. On 8/1/13 patient had complaints of pain, numbness/tingling in her hands, right elbow pain and shooting pain in her wrist, palms and forearm. A request for PT for bilateral wrists was made. The request is PT 2 x 6 for bilateral wrists was previously denied on 8/15/13 and again on 8/23/13 due to no documentation of objective findings from prior PT patient has received and how much PT she has already had. The issue presented again is whether PT 2 x 6 for bilateral wrists is medically necessary.

### **Documents Reviewed for Determination:**

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



**1) Regarding the request for physical therapy 2 times a week for 6 weeks to the bilateral wrists :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, pg. 98-9, which is a part of the MTUS.

Rationale for the Decision:

MTUS guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. A review of the records indicates there is no documentation submitted of what actual therapy the employee has had in the past. The documentation states that the employee has had therapy but there are no notes submitted from the employee's therapy visits with objective findings, how many visits the employee has had, and what functional gains have been made. There is no clinical notes to support the medical necessity of the physical therapy. **The request for physical therapy 2 times a week for 6 weeks to the bilateral wrists is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations



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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.