

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 8/22/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/1/2013
Date of Injury:	2/1/2012
IMR Application Received:	7/9/2013
MAXIMUS Case Number:	CM13-0001055

- 1) MAXIMUS Federal Services, Inc. has determined the requested physical therapy 2 x 6 for the RUE and bilateral hands and wrist **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/9/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/9/2013. 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 requested physical therapy 2 x 6 for the RUE and bilateral hands and wrist **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 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 1, 2013:

“History: The 59 year old female claimant injured her upper extremities on 02/01/12 and has been diagnosed with carpal tunnel syndrome. On 05/31/13, she saw Dr. [REDACTED] and she was frustrated and was unable to participate in more PT. Her left upper extremity was improving but she had issues with her shoulder, arm, hand, and wrist with numbness and tingling. She had pain from her neck to her hand. She had cervical spine stiffness and spasm with decreased range of motion and symptoms radiating to the shoulder with weakness of the rotator cuff. She had signs of CTS on the right. She also has cervical stenosis, bilateral shoulder bursitis, bilateral lateral epicondylitis and a left wrist ganglion cyst. Her neck and shoulder were denied body parts. Additional PT was recommended. Cited Guideline: California MTUS 9792.24.2. Chronic Pain Medical Treatment Guidelines; ODG, Forearm, Wrist, & Hand (Acute & Chronic), carpal tunnel syndrome Physical Medicine 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. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks.”

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:

- Application for Independent Medical Review dated 7/09/2013
- Utilization Review Determination provided by [REDACTED] dated 7/01/2013
- Medical Records dated from 6/14/2012 through 5/31/2013

- Chronic Pain Medical Treatment Guidelines, 2009, Physical Medicine, pages 98-99
- Official Disability Guidelines, Current Version, Shoulder Chapter, Physical Therapy
- Official Disability Guidelines, Current Version, Pain Chapter, Physical Medicine Treatment

1) Regarding the request for physical therapy 2 x 6 for the RUE and bilateral hands and wrist:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, 2009, Physical Medicine, pages 98-99, of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines, Current Version, Shoulder Chapter, Physical Therapy, and Pain Chapter, Physical Medicine Treatment, a Medical Treatment Guideline (MTG) not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the MTUS guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the upper extremities in an accident on 2/01/2013. The diagnosis was carpal tunnel syndrome, cervical spinal stenosis, bilateral lateral epicondylitis, and right shoulder rotator cuff full thickness tear with 5mm retraction. The employee was given physical therapy (PT) and occupational therapy (OT). The submitted and reviewed medical records revealed the employee has had 16-17 PT visits between late 2012 and May 1, 2013. The request was made for physical therapy two times per week for six weeks for the right upper extremities (RUE) and bilateral hands and wrists.

The MTUS recommends 9-10 sessions of PT for myalgia, neuralgia or radiculitis. The submitted records indicate that the employee has had 16-17 visits which exceeds the recommended number per the guidelines. The requested physical therapy 2 x 6 for the RUE and bilateral hands and wrist 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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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.