

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

December 19, 2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/30/2013
Date of Injury: 3/3/2013
IMR Application Received: 8/7/2013
MAXIMUS Case Number: CM13-0008059

Dear Mr./Ms. [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: PARTIAL OVERTURN. This means we decided that some (but not all) 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 Orthopaedic Surgery and Hand Surgery, and is licensed to practice in 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 57-year-old female who reported a work-related injury on 03/03/2011, as a result of cumulative trauma. The patient presents for treatment of the following diagnosis, postoperative bilateral carpal tunnel release. The clinical note dated 05/30/2013 documents the patient underwent a right carpal tunnel release on 08/16/2011, left carpal tunnel release on 11/01/2011. The patient attended postoperative physical therapy course of treatment, and an additional physical therapy visits with no lasting benefit per the clinical note provided by Dr. [REDACTED]. The provider documented upon physical exam of the patient, bilateral wrist motion was noted to be at dorsiflexion of 60 degrees, palmar flexion 90 degrees, ulnar deviation 40 degrees, radial deviation 20 degrees. The patient had 5/5 motor strength noted throughout with decreased sensation about the right thumb, index and long finger and about the left thumb and index finger. The provider requested multiple treatment recommendations to include authorization to start Pamelor for chronic neuropathic pain 10 mg 1 to 2 at night and consider physical therapy interventions in the future after the patient has progressed with the recommended treatment.

IMR DECISION(S) AND RATIONALE(S)

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

1. Physical therapy two (2) times a week for three (3) weeks to the bilateral wrists is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine Guidelines, pg. 99, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The current request previously received an adverse determination due to lack of documentation evidencing employee's reports of efficacy with previous physical therapy interventions and when the employee had last utilized physical therapy. The provider Dr. [REDACTED] documents on the clinical note dated 05/30/2013 the employee, postoperative to a bilateral carpal tunnel release, utilized a course of physical therapy. The employee continued treatments with a different provider and attended additional physical therapy visits with no lasting benefits. California MTUS indicates, "allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine." At this point in the employee's treatment, utilization of independent home exercise program would be indicated. Given the lack of significant objective findings and functional deficit upon exam of the employee, as well as lack of documented efficacy of previous physical therapy, **the request for physical therapy at 2 times per week for 3 weeks to the bilateral wrists is not medically necessary and appropriate.**

2. Pamelor 10mg #15 per month with 2 refills is medically necessary and appropriate.

The Claims Administrator based its decision on the the Chronic Pain Medical Treatment Guidelines, Antidepressants for chronic pain, Specific Antidepressants, pg. 15, which is part of the MTUS..

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antidepressants for chronic pain, pg. 13, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The current request previously received an adverse determination due to a lack of documented efficacy of this medication for the patient's pain complaints. However, it appears it was initially prescribed on 05/30/2013. The provider documents the patient utilizes Meloxicam, Tylenol extra strength, Levothroid, Simvastatin, and aspirin. California MTUS indicates, "Antidepressants for chronic pain are recommended as a first line option for neuropathic pain and is a possibility for non-neuropathic pain." As the patient has just begun utilization of this medication under presentation with Dr. [REDACTED] the current request is supported. However, future request for this medication must evidence documentation of efficacy as noted by a decrease in rate of pain on a VAS and increase in objective functionality. **The request for Pamelor 10mg #15 per month with 2 refills is medically necessary and appropriate.**

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.

[REDACTED]

CM13-008059