
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

December, 20, 2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/24/2013
Date of Injury: 7/31/2012
IMR Application Received: 8/16/2013
MAXIMUS Case Number: CM13-0013308

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: 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Ohio 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 58-year-old female who reported injury on 07/31/2012 with the mechanism of injury not being provided. The patient was noted to have been certified for 20 outpatient occupational therapy visits. The patient had pain in the left wrist and pain in the thumb. The patient was noted to have an injection in the right thumb in the past and had 4 sessions prior for occupational therapy but the patient was noted to have extremely weakness. The patient's diagnoses were noted to include thumb pain, wrist joint pain, and lateral epicondylitis of the elbow. The request was made for outpatient occupational therapy 2 times a week for 3 weeks.

IMR DECISION(S) AND RATIONALE(S)

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

1. Outpatient occupational therapy two times (2) per week for three (3) weeks is not medically necessary and appropriate.

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) guidelines, which is part of the MTUS.

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

The Physician Reviewer's decision rationale:

The clinical documentation submitted for review indicated the employee had extreme weakness to the right thumb. The physical examination revealed the employee had a decrease range of motion, and tenderness to the right thumb and bony tenderness. It was stated that the employee was seen by an orthopedist at [REDACTED] previously and received a cortisone injection for the left de Quervain's tenosynovitis which helped in the dorsal extensor compartment. That visit was noted

to have been within the week prior to the examination of 07/05/2013. CA MTUS Chronic Pain Guidelines recommend physical medicine for myalgias and myositis unspecified for 9 to 10 visits over 8 weeks. The clinical documentation submitted for review indicated that the employee had approximately 20 sessions of physical therapy that had been approved. However, clinical documentation submitted for review failed to provide the employee's functional deficits as well as the employee's objective response to the physical therapy that was previously participated in. **The request for occupational therapy 2 times a week for 3 weeks is not 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.

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