MAXIMUS Federal Services

Case Number:	CM14-0097635		
Date Assigned:	07/25/2014	Date of Injury:	03/13/2013
Decision Date:	09/23/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	06/17/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic 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 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

The injured worker is a 49 year old female who reported a date of injury of 03/13/2013. The mechanism of injury was a laceration to the right little finger. The injured worker had a diagnosis of right fifth-digit extensive tendon laceration, Mallet finger, swan neck deformity right little finger. The injured worker had been treated with medications and 12 sessions of physical therapy from 01/20/2014 through 02/10/2014. The injured worker had a MRI of the right hand on 04/17/2014. There were no pertinent surgeries documented in the medical records provided. The clinical note dated 06/02/2014 included documentation indicating that the injured worker had only attended two therapy visits with no progress. The clinical note dated 05/05/2014 the injured worker had complaints of pain with limited flexion of the right little finger. Clinical findings included mallet finger and Swan-neck deformity with inadequate effort with flexion and poor compliance with exercises. The injured worker had been using Ultram ER for pain management. The treatment plan included occupational therapy three times a week for four weeks and medications. A rationale was not provided in the medical records received. The request for authorization form was received on 06/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational Therapy 3x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for occupational therapy three times a week for six weeks is not medically necessary. The clinical note dated 06/02/2014 documented the injured worker had only attended two therapy visits and had not made any progress. The clinical note dated 05/05/2014 the injured worker had complaints of pain with limited flexion of the right little finger. The clinical findings included mallet finger and Swan-neck deformity with inadequate effort with flexion and poor compliance with exercises. The injured worker had previously been treated with 12 sessions of physical therapy from 01/20/2014 through 02/10/2014 with no documentation of the injured workers progression. The California MTUS guidelines state Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical medicine allows for fading of treatment frequency from up to 3 visits per week to one or less, plus active self-directed home physical medicine. The guidelines recommend 8-10 sessions of occupational therapy over 4 weeks. The injured worker was examined on 06/02/2014 and it is noted she attended two sessions of therapy without progression. The clinical note dated 05/05/2014 stated the injured worker had poor compliance with exercises and no quantitative progression. There is a lack of documentation indicating the injured worker has experienced significant objective functional improvement with the prior therapy. Within the provided documentation the requesting physician did not provide a recent complete assessment of the injured worker's objective functional condition in order to demonstrate deficits for which therapy would be indicated. Additionally, the site which the therapy is for is not indicated. As such, the request is not medically necessary.