MAXIMUS Federal Services

Case Number:	CM15-0108478		
Date Assigned:	06/15/2015	Date of Injury:	10/28/2011
Decision Date:	07/14/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 28-year-old female who sustained an industrial injury on 10/28/2011. Current diagnosis includes exacerbation of de Quervain tendinitis. Previous treatments included medications, modified activities, and therapy. Report dated 04/30/2015 noted that the injured worker presented with complaints that included pain in the left thumb and left hand, and decreased grip strength. Pain level was not included. Physical examination was positive for reduced strength in the left hand, mild swelling, positive left Finkelstein test. The treatment plan included recommendations for occupational therapy, refilled Voltaren gel, placed on modified duty, follow up with surgeon, and return in 2-3 weeks. Disputed treatments include occupational therapy three times per week for three weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy, three times a week for three weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapy, pages 98-99.

Decision rationale: Occupational therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified occupational therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the OT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of occupational therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal OT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further occupational therapy when prior treatment rendered has not resulted in any functional benefit. The Occupational therapy, three times a week for three weeks is not medically necessary and appropriate.