MAXIMUS Federal Services

Case Number:	CM14-0097755		
Date Assigned:	09/08/2014	Date of Injury:	06/22/2011
Decision Date:	10/14/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/18/2014

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 Physical Medicine and Rehabilitation, Pain Medicine, 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 48 year old female who was injured on 06/22/11. There are no clinical notes submitted for review. The submitted documentation includes a request for authorization of physical therapy, twice per week for four weeks, for the bilateral upper extremities dated 05/28/14 and a Utilization Review dated 06/04/14. The mechanism of injury is not described in this documentation. The UR indicates the injured worker is status post long finger repair performed on 02/25/14. It is noted the injured worker continued to report pain as of 04/14/14 and additional trigger finger release was being considered. The injured worker reportedly demonstrated diffuse tenderness to the base of the right long finger adjacent to the A1 Pulley. It is noted the injured worker had completed approximately 14 sessions of physical therapy for the bilateral upper extremities previously. This UR denied the request for additional physical therapy citing no demonstrated medical necessity for further physical therapy based on applicable guidelines. It is noted no ROM, VAS or motor muscle testing was provided. This is an appeal request for physical therapy twice per week for four weeks for the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient physical therapy two (2) times a week x 4 to the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99 of 127.

Decision rationale: The request for Outpatient physical therapy two (2) times a week x 4 to the bilateral upper extremities is not recommended as medically necessary. MTUS Chronic Pain Medical Treatment Guidelines state, "Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort." There were no clinical records submitted for review. As such, there are no physical examination or subjective complaints which identify functional limitations or significant pain that would warrant treatment with physical therapy. Based on the lack of clinical information, medical necessity of Physical Therapy 2 Times Per Week For 4 Weeks For The Bilateral Upper Extremities is not established.