MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 11/21/2013

Employee:	
Claim Number:	
Date of UR Decision:	8/9/2013
Date of Injury:	2/9/2012
IMR Application Received:	8/13/2013
MAXIMUS Case Number:	CM13-0010627

1) MAXIMUS Federal Services, Inc. has determined the request for **capsulectomy or capsulotomy four times is medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **post op therapy two times a week for eight weeks is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 8/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/18/2013. A decision has been made for each of the treatment and/or services that were in dispute:

1) MAXIMUS Federal Services, Inc. has determined the request for **capsulectomy or capsulotomy four times is medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **post op therapy two times a week for eight weeks is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:
The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:
The claimant is a 51 year-old, right hand dominant male who fell about 2-3 feet out of a truck and placed his right hand out to break the fall injuring his right wrist on 02/09/12. On 02/17/12 he underwent an open reduction internal fixation (ORIF) of the right distal radius and ulna; he developed complex regional pain syndrome postoperatively. On 04/10/12 he underwent a right open carpal tunnel release. The claimant had ongoing right wrist and hand pain and treated through 04/23/13 with Dr. [redacted] and Dr. [redacted] with Norco, Neurontin, modified duty/off work and 24 visits of occupational therapy between May and 08/23/12. On 06/21/12 Dr. [redacted] reviewed x-rays of the right wrist taken on 05/17/12 to show intact hardware without signs of loosening or breakage at the distal radius. There was near anatomic reduction and healing of the distal radius. He restarted therapy on 03/04/13.

The claimant had ongoing pain and stiffness in the MP and PIP joints of the right hand despite therapy and off work. Dr. [redacted] recommended a capsulectomy of the MP joints of the right index, middle, ring and little fingers.

Dr. [redacted] performed a Qualified Medical Evaluation on 07/26/13 noting the surgery had been denied. The claimant complained of right hand/wrist pain with stiffness, weakness in the hands/fingers and joint pain and pain radiating up to the right shoulder with numbness and tingling of all the fingers of the right hand. He was taking Tylenol # 3 and Norco. He was noted to be a smoker. Dr. [redacted] indicated that the claimant had a very protracted recovery from the initial fracture to the right wrist. He agreed with Dr. [redacted] recommendation for additional surgery.

A 08/09/13 review by Dr. [redacted] denied the requested surgery and postoperative physical therapy due to insufficient physical examination findings as the only information noted was stiffness of the MP joints and the lack of current specific range of motion recorded.

Dr. [redacted] saw the claimant on 08/13/13 at which time range of motion of the right wrist was flexion 0-50 degrees and extension 0-55 degrees. Range of motion of the index finger was: MCP 0-50 degrees, PIP 10-95 degrees, and DIP 0-30 degrees; middle finger MCP was 0-50 degrees, PIP 25-95 degrees and DIP 0-35 degrees; ring finger MCP 0-45 degrees, PIP 10-100 degrees and DIP 0-40 degrees; little finger MCP 0-50 degrees, PIP 15-90 degrees and DIP 0-50 degrees. Dr. [redacted] authored a letter of appeal on 08/15/13 and reviewed the physical examination findings from 08/13/13. He stated that range of motion was mostly limited at the MP joint which has a significant effect on the function of the fingers. He indicated that the condition can be improved with capsulectomy of the MP joints. Dr. [redacted] saw the claimant on 09/10/13 and noted no change in his condition. There was stiffness of the wrist and fingers and a scar of the volar distal forearm. Surgery was pending.

Documents Reviewed for Determination:
The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for capsulectomy or capsulotomy four times:**

<u>The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision</u>
The Claims Administrator based its decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), Surgical Considerations, which is part of the MTUS, and the Post Surgical Treatment Guidelines, Forearm, Wrist, & Hand, which is part of the MTUS

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), Surgical Considerations, page 270, which is part of the MTUS.

<u>Rationale for the Decision:</u>
The requested procedure of a capsulotomy times four does appear to be medically necessary in this case. By history, this employee is status post open reduction internal fixation of the distal radius and ulna as well as previous carpal tunnel surgery. It appears, based on the records provided, that the employee has been through significant episodes of physical therapy and occupational therapy in 2012 and 2013. It appears that the employee has continued to suffer from contracture of the metacarpophalangeal regions. A most recent note by Dr. [redacted] dated 8/13/13 noted range of motion of the index finger from 0-50° at the

metacarpophalangeal joint. The middle finger revealed metacarpophalangeal motion 0-50°, and ring finger metacarpophalangeal motion from 0-45°. The employee's little finger metacarpophalangeal motion was 0-50°. With these significant restrictions of motion, the employee has limited function of the fingers. Guidelines are somewhat silent with regard to the utilization of capsulotomy; however, in this case, it appears that this employee has gone through significant episodes of conservative measures. As such, the role of capsulotomy appears to be relatively appropriate in this case. The request for capsulectomy or capsulotomy four times is medically necessary and appropriate.

2) **Regarding the request for post op therapy two times a week for eight weeks:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Post Surgical Treatment Guidelines, Forearm, Wrist, & Hand, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), Surgical Considerations, page 270, which is part of the MTUS., and the Post Surgical Treatment Guidelines, Forearm, Wrist, & Hand, which is part of the MTUS.

Rationale for the Decision:

With regard to post-operative therapy two times per week for eight weeks, this also appears to be appropriate based on California MTUS Post Surgical Guidelines with regard to post-surgical management for capsulotomy which proposes 24 visits over two months. The request for post op therapy two times a week for eight weeks is medically necessary and appropriate.

Effect of the Decision:
The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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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.