
Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/3/2013
Date of Injury: 10/17/2003
IMR Application Received: 8/16/2013
MAXIMUS Case Number: CM13-0011686

- 1) MAXIMUS Federal Services, Inc. has determined the request for **right basal joint interpositional arthroplasty is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **right flexor carpi radialis tendon graft is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **excision right trapezium is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Mitek anchor system for first and second metacarpals is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **K-wire fixation first to second metacarpal and release of right first dorsal compartment is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **post operative occupational therapy three (3) times a week for four (4) weeks is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **custom splint is not medically necessary and appropriate.**

- 8) MAXIMUS Federal Services, Inc. has determined the request for **CPM rental for 30 days is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for **cold therapy unit rental for 30 days is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/16/2013 disputing the Utilization Review Denial dated 8/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/24/2013. 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 **right basal joint interpositional arthroplasty** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **right flexor carpi radialis tendon graft** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **excision right trapezium** is not **medically necessary and appropriate**.
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- 8) MAXIMUS Federal Services, Inc. has determined the request for **CPM rental for 30 days** is not **medically necessary and appropriate**.
- 9) MAXIMUS Federal Services, Inc. has determined the request for **cold therapy unit rental for 30 days** is not **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 General 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 72-year-old female who reported an injury on 10/17/2003, mechanism of injury not stated. Diagnoses given include bilateral lateral epicondylitis, bilateral carpal tunnel syndrome, stenosing tenosynovitis of the right thumb, stenosing tenosynovitis of the left thumb, right de Quervain's disease, bilateral degenerative traumatic basal joint arthritis status post right carpal tunnel release 10/02/2012, tenosynovitis of the right little finger. A clinical note signed by Dr. [REDACTED] dated 03/18/2013 reported the patient reported she began to experience the gradual onset of numbness and tingling of her bilateral hands, left side worse than right during the course of performing her regular duties. She noted that up to 75% of her work day was spent keyboarding. She noted that sometime in 2004, she started utilizing a cane for assistance with ambulating and would alternate using the cane between her left hand greater than her right hand, and she noted over time, a worsening of her bilateral wrist and hand symptoms. She was reported to have been treated with injections to the MCP joints, the right first dorsal compartment and right carpal tunnel. The patient reported pain and swelling of her right and left hands, fingers, and wrist, numbness and tingling of the right and left hand, fingers, and wrist, radiating pain from the left wrist to the left thumb, radiating pain from the right wrist to the right index finger, radiating pain down the left forearm from the elbow to the thumb, weakness of the right and left hands, fingers, and wrists with difficulty grasping and gripping and dropping objects. On physical examination of the left hand the patient is noted to have a positive Finkelstein test on the right, very positive grind test and CMC 1 stress load test on the right, tenderness to palpation over the volar aspect of the MCP joint, and triggering of the right thumb and little finger. The motion of the wrist was normal bilaterally, strength was noted to be normal bilaterally, and range of motion of the right thumb was reported to be normal with 0 to 60 degrees at the MCP joint and 0 to 80 degrees of the DIP joint X-rays of the right and left thumbs were ordered. Clinical note dated 04/01/2013 signed by Dr. [REDACTED] reported the patient received an injection of lidocaine and Kenalog to the right thumb A1 pulley, right little finger A1 pulley, and the right dorsal compartment which the is reported to have tolerated well.

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:

[REDACTED]

1) Regarding the request for right basal joint interpositional arthroplasty :

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Forearm, Wrist and Hand Complaints, Chapter 11, pgs. 271-273, table 11-7, which is part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Forearm, Wrist, & Hand (Acute & Chronic), Arthroplasty, finger and/or thumb (joint replacement).

Rationale for the Decision:

The employee reported an injury on 10/17/2003 due to cumulative trauma while performing job duties. The employee was reported to have experienced gradual onset of pain and numbness of bilateral hands, left side worse than right during the course of performance of regular duties as the employee spent 75% of the work day keyboarding. The employee is noted to have previously undergone a Kenalog injection to the right first dorsal compartment and into the right carpal tunnel, but continued to experience swelling of the right thumb, popping of the right thumb, pain, and swelling in the knuckles of the right little finger. The employee is noted to have normal range of motion of the right thumb with a positive Finkelstein, tenderness to palpation over the volar aspect of the MCP joint, with triggering of the right thumb, very positive grind test and CMC stress loading. The employee is reported to have undergone x-rays on an unstated date which were reported to show CMC joint arthritis. However, as the employee is not noted to have an abnormal range of motion of the thumb and although the employee has reported to have undergone x-rays of the right thumb joint which are reported to show osteoarthritis of the thumb, there is no documentation of recent x-rays having been performed. **The request for right basal joint interpositional arthroplasty is not medically necessary and appropriate.**

2) Regarding the request for right flexor carpi radialis tendon graft:

Since the primary procedure right basal joint interpositional arthroplasty is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

3) Regarding the request for excision right trapezium:

Since the primary procedure right basal joint interpositional arthroplasty is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

4) Regarding the request for Mitek anchor system for first and second metacarpals:

Since the primary procedure right basal joint interpositional arthroplasty is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

5) Regarding the request for K-wire fixation first to second metacarpal and release of right first dorsal compartment:

Since the primary procedure right basal joint interpositional arthroplasty is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

6) Regarding the request for post operative occupational therapy three (3) times a week for four (4) weeks:

Since the primary procedure right basal joint interpositional arthroplasty is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

7) Regarding the request for custom splint :

Since the primary procedure right basal joint interpositional arthroplasty is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

8) Regarding the request for CPM rental for 30 days:

Since the primary procedure right basal joint interpositional arthroplasty is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

9) Regarding the request for cold therapy unit rental for 30 days:

Since the primary procedure right basal joint interpositional arthroplasty is not medically necessary and appropriate, none of the associated services are 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

/ldh

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.