

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/30/2013
Date of Injury: 10/5/2013
IMR Application Received: 8/16/2013
MAXIMUS Case Number: CM13-0012090

Dear Mr./Ms. [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Sport Medicine 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 physician 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.

DOCUMENTS REVIEWED

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

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

The patient is a 64-year-old female who reported an injury on 10/06/2009. The mechanism of injury was not reported. The patient had continued wrist and knee pain. Physical findings included a positive Tinel's and Phalen's sign. The patient had decreased sensation in the radial 3 digits with tenderness over the carpal tunnel area. The patient also had continued knee complaints that were treated with Synvisc injections. The patient underwent surgery for a right hand carpal tunnel release on 07/23/2013. Postsurgically, the patient did not report any issues and an improvement in numbness and tingling. The patient's diagnoses included bilateral knee arthritis with pre-existing significant trauma flare up, and right hand carpal tunnel syndrome. The patient's treatment plan included range of motion exercises and physical therapy.

IMR DECISION(S) AND RATIONALE(S)

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

1. Dynamic contrast therapy system with wrap rental for 21 days is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician 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 Official Disability Guidelines (ODG), Carpal Tunnel Chapter, Continuous cold therapy (CCT), which is not part of the MTUS.

The Physician Reviewer's decision rationale:

A dynamic contrast therapy system with wrap rental x21 days is not medically necessary or appropriate. The patient had a positive response to surgical intervention. California Medical Treatment Utilization Schedule (MTUS) does not address this request. The Official Disability Guidelines recommend continuous cold therapy as an option in the postoperative setting. However, recommended use is no more than 7 days. The clinical documentation submitted for review indicated that the patient did not have any significant issues postsurgically that would require cryotherapy. There were no significant pain complaints or evidence of significant inflammation related to the surgical intervention. **The request for a dynamic contrast therapy system with wrap rental for 21 days is not medically necessary and appropriate.**

/skf

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.

[REDACTED]

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