
Independent Medical Review Final Determination Letter

294

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/31/2013

IMR Case Number:	CM13-0015365	Date of Injury:	01/01/2013
Claims Number:	[REDACTED]	UR Denial Date:	08/13/2013
Priority:	STANDARD	Application Received:	08/22/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]	M.D.	
Treatment(s) in Dispute Listed on IMR Application:			
SEE ATTACHED PAGE 2			

DEAR [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 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 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 claimant is a 35 year old female injured January 1, 2103. The claimant was with complaints of bilateral upper extremity pain from the shoulders to the digits from a work accident. She was initially diagnosed with bilateral carpal tunnel syndrome, DeQuervain's tenosynovitis, medial and lateral epicondylitis. The recent clinical assessment dated August 28, 2013 with [REDACTED] stated the claimant since the injury has been treated with immobilization, physical therapy, splinting, work restrictions and medications. Surgical history to the right upper extremity includes a carpal tunnel release with DeQuervain's release July 30, 2013. At present her left wrist is with positive Phalen's, Tinel's and carpal compression testing, right greater than left, pain with resisted wrist flexion and extension and tenderness over the first extensor compartment of the right greater than left wrist with a positive Finklestein test. The diagnosis was left greater than right carpal cubital tunnel syndrome as well as DeQuervain's tenosynovitis, surgery was recommended in the form of a DeQuervain's release. It states the claimant denied corticosteroid injections.

IMR DECISION(S) AND RATIONALE(S)

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

1. Left de Quervain's tenolysis is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, page 271, which is part of the MTUS and the Official Disability Guidelines (ODG), Forearm, Wrist and Hand, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 11, Page 271, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on the CA ACOEM Guidelines DeQuervain's release to the left wrist is not supported. The claimant's clinical symptoms are consistent with first dorsal extensor compartment tendinosis, however there is no documentation of treatment that includes injection therapy. The guidelines only recommend the role of this procedure in situations that do not respond to more adequate forms of first line treatment and the absence of documented treatment including injections would fail to support a need for surgical intervention at this time.

2. Postoperative physical therapy Qty: 6 is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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]

CM13-0015365