

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/9/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/19/2013
Date of Injury:	1/2/2012
IMR Application Received:	8/28/2013
MAXIMUS Case Number:	CM13-0017489

- 1) MAXIMUS Federal Services, Inc. has determined the request for **one range of motion of the right hand is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **nine additional chiropractic treatments is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/28/2013 disputing the Utilization Review Denial dated 8/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **one range of motion of the right hand is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **nine additional chiropractic treatments is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Expert Reviewer who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Chiropractic 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:**

According to the available medical records, this is a 35 year old female patient with chronic right thumb pain and right wrist pain (deQuervain's) with date of injury 01/02/2012. Previous treatments include thumb Spica brace, medications, physical therapy, injection, right deQuervain's release and right trigger thumb release on 05/09/2013. Post-operative treatment, per PR-2 report dated 5/23/2013, includes chiropractic treatment, exercises rehab with modalities and post/op rehab for the right trigger thumb and right wrist, 3 times a week for 4 weeks, chiropractic treatment hand-written note was not readable. PR-2 report from Dr. [REDACTED] dated 06/19/2013 revealed continue burning of her right thumb, index and middle fingers, no triggering of the thumbs and decreased numbness/tingling, examination revealed slight positive Finkelstein, scar tissues noted at the surgical sites, decreased right wrist AROM, treatment plan is to complete remaining 4 post-op chiropractic treatment and request authorization for additional post-op chiro services with exercises and modalities to the right wrist and right thumb 2x3 weeks to decrease scar tissue, increase ROM and increase muscle strength.

### **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 one range of motion of the right hand:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Postsurgical Treatment Guidelines, which is a part of 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, Low Back Chapter, and American Medical Association Guidelines (5<sup>th</sup> Edition).

Rationale for the Decision:

The Official Disability Guidelines state, flexibility is not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. This has implications for clinical practice as it relates to disability determination for patients with chronic low back pain, and perhaps for the current impairment guidelines of the American Medical Association. The AMA Guide to the Evaluation of Permanent Impairment state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way." **The request for one range of motion of the right hand is not medically necessary and appropriate.**

**2) Regarding the request for nine additional chiropractic treatments:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Postsurgical Treatment Guidelines, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, Radial styloid tenosynovitis (de Quervain's), pg. 22, which is a part of MTUS.

Rationale for the Decision:

The MTUS guidelines for post-operative physical therapy indicate for Radial Styloid tenosynovitis (deQuervain's): postsurgical treatment is 14 visits over 12 weeks. The guidelines indicate the postsurgical physical medicine treatment period is 6 months. The medical records reviewed indicates the employee has completed 9 visits of postoperative chiropractic treatments. The request for 9 additional visits exceeds the guideline recommendation of 14 visits. **The request for nine additional chiropractic treatments is not 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, 18<sup>th</sup> 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.