
Independent Medical Review Final Determination Letter

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Dated: Select Date

IMR Case Number:	CM13-0017869	Date of Injury:	07/10/2011
Claims Number:	██████████	UR Denial Date:	08/23/2013
Priority:	STANDARD	Application Received:	08/28/2013
Employee Name:	████████████████████		
Provider Name:	██████████ M.D.		
Treatment(s) in Dispute Listed on IMR Application:			
MULTIPLE			

DEAR ██████████

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, ██████████

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 & Rehabilitation, has a subspecialty in Pain Management 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:

This is a male patient with a date of injury of July 10, 2011. Diagnoses by Dr. [REDACTED] included lumbar sprain/strain with disc protrusion with left lumbar radiculopathy, cervical sprain/strain with multilevel disc protrusion with left cervical radiculitis, right shoulder sprain/strain, impingement and rotator cuff tear, status post right shoulder arthroscopy with rotator cuff repair, bilateral plantar fasciitis with metatarsalgia, and bilateral wrist pain, carpal tunnel syndrome. The provider's note goes on to state, "with regard to his feet, the patient had been fitted with custom orthotics and noted overall improvement." The patient was declared permanent and stationary by Dr. [REDACTED] for this injury. With regard to the patient's both hands and wrists, Dr. [REDACTED] diagnosed him with carpal tunnel syndrome and recommended bilateral wrist braces and electrical stimulation unit. He also requested EMG nerve conduction velocity studies, as his case was denied. The note goes on to indicate that following the patient's initial examination in the office, authorization was requested for the recommended neuro-diagnostic studies of the upper extremities to rule out cervical radiculopathy or peripheral neuropathy such as carpal tunnel syndrome. Other diagnostic studies were also felt to be necessary including diagnostic musculoskeletal ultrasound studies of the wrist to rule out ligament or tendon pathology and to assess the median nerves in the carpal tunnels. The patient was administered two cortisone injections to the left heel and one in the right heel. He noted only temporary relief following each injection. He was referred for a short course of therapy and he was provided with custom foot orthotics. Physical examination performed on August 9, 2013 identified tenderness to palpation over the dorsal capsules and flexor tendons and muscle groups of the wrists and distal forearms, right side worse than left.

IMR DECISION(S) AND RATIONALE(S)

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

1. The request for 12 sessions of chiropractic services is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are a part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 58-60, which are part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines state that chiropractic care is not recommended for forearm, wrist, and hand complaints. Within the medical records available for review, the requesting physician has indicated that the chiropractic care is being used to treat the employee's bilateral wrists and hands. **The request for chiropractic care is not medically necessary and appropriate.**

2. Extracorporeal shockwave therapy (ESWT) for plantar fasciitis is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 14, Ankle and Foot Complaints, pages 368 and 376, which is a part of the MTUS, as well as the ODG, Ankle and Foot chapter, which is not a part of the MTUS.

The Physician Reviewer's decision rationale:

Occupational Medicine Practice Guidelines state that ESWT is recommended as an optional treatment for plantar fasciitis. The ODG state that the criteria for the use of extracorporeal shockwave therapy includes patients with heel pain from plantar fasciitis for at least 6 months, failure of at least 3 conservative treatments (rest, ice, NSAIDs, orthotics, physical therapy, or injections). The guidelines go on to recommend a maximum of 3 therapy sessions over 3 weeks. Within the medical records available for review, it is clear the employee's heel pain has been present for an extended period of time. Notes indicate that the employee improved with custom orthotics. Following that initial improvement, there is no documentation indicating whether or not the employee continued to use the custom orthotics. There should be documentation that the custom orthotics have been tried consistently, prior to consideration for ESWT. Additionally, the current request for ESWT does not request a specific number of visits. Guidelines clearly do not support the open-ended use of ESWT, and recommend only 3 visits over 3 weeks. In light of the above issues, the currently requested extracorporeal shock wave therapy is not medically necessary. **The request for ESWT for treatment of plantar fasciitis is not medically necessary and appropriate.**

3. Diagnostic musculoskeletal ultrasound of the wrists is not medically necessary and appropriate.

The Claims Administrator based its decision on the ODG, Wrist Chapter, which is not a part of the MTUS.

The Physician Reviewer based his/her decision on the ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, Forearm, Wrist and Hand Complaints, page 269, which is a part of the MTUS, as well as the ODG, Wrist Chapter, Ultrasound, which is not a part of the MTUS.

The Physician Reviewer's decision rationale:

Occupational Medicine Practice Guidelines do not contain specific criteria regarding the use of diagnostic ultrasound. They do, however, state that if symptoms have not resolved in 4 to 6 weeks, imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggests specific disorders. ODG indicate that ultrasonography is a dynamic process and is accurate in detecting tendon injuries. Within the clinical notes available for review, it does not appear that the employee has had conservative treatment with regard to the tendon complaints for at least 4-6 week as recommended by guidelines. Documentation provided for review does not include any physical examination findings related to the tendons in the employee's wrist prior to the August 12, 2013 supplemental report. Additionally, there is no documentation of conservative treatment aimed towards the suspected tendon pathology. In the absence of such documentation, the currently requested musculoskeletal ultrasound for diagnosis of the wrist is not medically necessary. **The request for diagnostic ultrasound studies of the wrists is not medically necessary and appropriate.**

/dso

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