

**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**

1120

[Redacted]

Dated: 12/18/2013

<b>IMR Case Number:</b>	CM13-0018552	<b>Date of Injury:</b>	03/26/2013
<b>Claims Number:</b>	[Redacted]	<b>UR Denial Date:</b>	08/20/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/29/2013
<b>Employee Name:</b>	[Redacted]		
<b>Provider Name:</b>	[Redacted]		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
PTLT WRIST			

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventral Spine 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from (Claims Administrator, employee/employee representative, Provider)
- Medical Treatment Utilization Schedule (MTUS)

### 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 IMR application shows the patient was injured on 3/26/13 and is disputing the 8/20/13 UR decision. The 8/20/13 UR decision is from [REDACTED] and was for denial of PT and a TENS unit. The rationale is that there was no improvement from prior chiropractic and therapy sessions. The request before me is “whether the PT left wrist is/are medically necessary”

This is a 30 YO, 5'9", 301 lbs, RHD, M who injured his left wrist on 3/26/13. He was attempting to remove a flight of stairs from a stage and it collapsed on his left hand.

### IMR DECISION(S) AND RATIONALE(S)

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

#### **1. Physical therapy (PT) left wrist is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Chapter on Hand, Wrist & Forearm Disorders, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 98-99, which are part of the MTUS.

The Physician Reviewer's decision rationale:

The submitted request was incomplete. The duration and frequency or total number of visits is not provided. The UR letter states they only looked at the 4/5/13 report and the

6/17/13 report and a wrist MRI from 6/14/13. There are various requests for chiropractic care with the latest report being 1-3x/2 on 6/10/13. Then on 6/17/13 the patient saw a provider who recommended PT 2x4, acupuncture 2x4, ESWT and DNA testing. The provider on 7/15/13 requests PT 2x6 and acupuncture 2x6. The employee's injury appears to be the left wrist, although the chiropractor was requesting the chiropractic care for the low back. Chiropractic care for the low back is not a prerequisite for PT on the wrist. PT 2x4 or 8 initial sessions would appear to be in accordance with MTUS guidelines, Unfortunately, the request provided does not include any specific number of PT visits. If the request was for the PT 2x6, it would exceed MTUS recommendations. The information required is the duration and frequency of visits requested, and total number of PT provided, if any, and any documentation of functional improvement if there was prior PT. There is not enough information provided to confirm that the physical therapy is provided in accordance with MTUS guidelines, and since "medical necessity" has been defined as treatment based on MTUS guidelines, this request cannot be considered medically necessary. **The request for PT left wrist is not medically necessary and appropriate.**

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]

CM13-0018552