
Notice of Independent Medical Review Determination

Dated: 10/14/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/9/2013

2/28/2012

7/19/2013

CM13-0002034

- 1) MAXIMUS Federal Services, Inc. has determined the request for 8 additional physical therapy sessions **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for bilateral wrist orthopedic bracing/thumb spica **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a home electric muscle stimulation unit/ortho stim 4 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the retrospective request for radiographic examination of bilateral shoulders, wrists and thumbs **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 8 additional physical therapy sessions **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for bilateral wrist orthopedic bracing/thumb spica **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a home electric muscle stimulation unit/ortho stim 4 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the retrospective request for radiographic examination of bilateral shoulders, wrists and thumbs **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision 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 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013

“Right shoulder pain with associated spasm, tenderness, and weakness with increasing pain with any repetitive pushing, pulling, gripping, and grasping, and lifting activities, work above shoulder level and difficulty sleeping. Left shoulder pain, not on claim form, with associated pain, tenderness, and spasm, and weakness, increase with ADLs and with any repetitive pushing, pulling, gripping, grasping, sleeping on his side at night, and working above shoulder level. Bilateral forearm, wrist, and hand pain with associated numbness and tingling primarily involving the thumb and index finger of both hands, right side greater than left, increasing symptoms with gripping, grasping, pushing, and pulling and lifting activities. Patient notes a fair result following surgical procedures to right wrist on 2/5/13, right wrist carpal tunnel release. Bilateral thumb pain, left side greater than right with increasing symptoms with any torquing, gripping, grasping, pushing, and pulling, and lifting activities, with associated swelling with increase ADLs.”

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 for Independent Medical Review (date 7/19/2013)
- Utilization Review by [REDACTED] (date 7/10/2013)
- Medical Records from [REDACTED] (date 1/11/2013)
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for 8 additional physical therapy sessions:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Physical Medicine section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance and also cited the Postsurgical Treatment Guidelines, Carpal Tunnel Syndrome section, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 2/12/2012, resulting in right shoulder and wrist injuries. Diagnoses include status post right carpal tunnel decompression. Treatment has included imaging, right wrist surgery, right carpal tunnel release, and prior post op physical therapy. The request is for 8 additional physical therapy sessions.

The MTUS Chronic Pain Medical Treatment Guidelines indicate that postsurgical treatment for an open carpal tunnel release would be 3 to 8 visits over 3 to 5 weeks. Furthermore, the MTUS Chronic Pain Guidelines advocate weaning of physical therapy visits and transition to a home exercise program. According to the medical records provided for review this employee has undergone at least 12 visits for carpal tunnel release. It would be reasonable that the employee be transitioned to a home exercise program at this time. The request for 8 additional physical therapy sessions **is not medically necessary and appropriate.**

2) Regarding the request for bilateral wrist orthopedic bracing/thumb spica :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Forearm, Wrist, and Hand Chapter, Splinting section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the American College of

Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, (2004), Hand and Wrist Chapter, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 2/12/2012, resulting in right shoulder and wrist injuries. Diagnoses include status post right carpal tunnel decompression. Treatment has included imaging, right wrist surgery, right carpal tunnel release, and prior post op physical therapy. The request is for bilateral wrist orthopedic bracing/thumb spica .

The ACOEM Guidelines indicate that when treating with a splint in CTS, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night, and may be used during the day, depending upon activity. Medical records provided for review failed to demonstrate a medical necessity for these devices. The request for bilateral wrist orthopedic bracing/thumb spica **is not medically necessary and appropriate.**

3) Regarding the request for a home electric muscle stimulation unit/ortho stim 4:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), which are part of the California Medical Treatment Utilization Schedule (MTUS), but did not cite a specific page or section. The Claims Administrator also cited the vendor's website (www.vqorthocare.com), which is a nationally recognized professional standard that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), page 116, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 2/12/2012, resulting in right shoulder and wrist injuries. Diagnoses include status post right carpal tunnel decompression. Treatment has included imaging, right wrist surgery, right carpal tunnel release, and prior post op physical therapy. The request is for a home electric muscle stimulation unit/ortho stim 4.

The MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention as there is lack of quality evidence of effectiveness except in conjunction with recommended treatments. Medical records provided for review failed to demonstrate a medical necessity for these devices. The employee is not currently undergoing therapy and this is not a standalone device. The request for a home electric muscle stimulation unit/ortho stim 4 **is not medically necessary and appropriate.**

4) Regarding the retrospective request for radiographic examination of bilateral shoulders, wrists and thumbs:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), pages 208-209 and Tables 8-1, 8-8, 9-1, 9-6, 10-1, 10-6, 11-6, 12-1, and 12-8, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Wrist and Shoulder Chapters, which are medical treatment guidelines that are not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 2/12/2012, resulting in right shoulder and wrist injuries. Diagnoses include status post right carpal tunnel decompression. Treatment has included imaging, right wrist surgery, right carpal tunnel release, and prior post op physical therapy. The request is for radiographic examination of bilateral shoulders, wrists and thumbs.

The ACOEM Guidelines state that relying only on imaging studies to evaluate the source of shoulder symptoms carries a significant risk of diagnostic confusion indicate possible falls positive test results. The medical records provided for review failed to indicate that there is any new trauma, especially with the bilateral shoulders or bilateral wrists, which would support follow-up x-rays. Furthermore, there is lack of a current objective physical exam to warrant medical necessity for these procedures. The ACOEM Guidelines do not support the request. The request for radiographic examination of bilateral shoulders, wrists and thumbs **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/mbg

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.