

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 10/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/18/2013
Date of Injury:	9/12/2012
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003577

- 1) MAXIMUS Federal Services, Inc. has determined the request for Right Thumb capular Repair CMC joint **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 Right Thumb capular Repair CMC joint **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 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 18, 2013:

“The patient is a female with reported Right wrist injury on 09/12/12. She had pain and reported mechanical symptoms in the Right thumb carpometacarpal (CMC) joint. X-rays and MRI studies were interpreted by radiologists as being normal. The treating provider opined that the x-rays showed progressive subluxation of the thumb CMC joint.”

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 dated 7/25/2013
- Utilization Review Determination from Claims Administrator [REDACTED] dated 7/18/2013
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Right Thumb capular Repair CMC joint:

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

The Claims Administrator based its decision on the Forearm, Wrist, and Hand Complaints, Surgical Considerations (ACOEM Practice Guidelines, 2nd Edition, (2004), Chapter 11), pg. 270 which is a part of Medical Treatment Utilization

Schedule (MTUS). The Expert Reviewer found the guidelines 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 09/12/12 resulting in the right wrist, and thumb injury. The medical records provided for review indicate treatments have included steroid injections, physical therapy, splinting, and medication management. The request is for right thumb capular repair CMC joint.

The MTUS/ACOEM Guidelines recommend a surgical procedure if there is clear clinical and special study evidence of a lesion that has been shown to benefit in the long term and short-term from surgical intervention. In this case, the employee is reported to have of visible subluxation of the CMC joint and reported to have progressive subluxation of the CMC joint by imaging studies, however, the imaging studies submitted for review do not corroborate these findings. The request for right thumb capular repair CMC joint **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

/hs

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.