

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/28/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	6/28/2013
Date of Injury:	7/5/2006
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004181

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy for the right wrist, 3 times a week for 4 weeks **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Norco 7.5/325mg, #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a DME purchase - right wrist brace **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 6/28/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/5/2013. 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 physical therapy for the right wrist, 3 times a week for 4 weeks **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Norco 7.5/325mg, #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a DME purchase - right wrist brace **is not medically necessary and appropriate.**

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

The 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 Physical Medicine and Rehabilitation 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 June 28, 2013:

“This 46-year-old female sustained an Industrial injury on 7/5/06. The mechanism of injury occurred when she slipped and fell when the bathroom was flooded. Her diagnoses included fracture of the distal radius and ulna, with scaphoid fracture. The clinical examination of 6/14/13, indicated ongoing aching sensation to the wrist with stiffness and swelling of the right wrist. Tenderness over the radial styloid was noted with ulnar sided wrist pain. Positive piano key sign for instability in the ulna was appreciable. Watson's and Finkelstein's tests were positive. These were present status post fusion of the right wrist. Wrist motion on the right was 60° flexion, 10° extension and was 0° of radial and ulnar deviation. Moderate weakness about the right wrist was noted. There were recommendations for physical therapy with work conditioning, a right wrist brace, and Norco for pain. Her work status was light duty work avoiding the use of the injured hand.”

### **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 (received 07/29/2013)
- Utilization Review Determination from [REDACTED] (dated 06/27/2013)
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request physical therapy for the right wrist, 3 times a week for 4 weeks:**

#### 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), pages 98-99, Physical Medicine Section, which are part of the California 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. The Expert Reviewer also relied on the Postsurgical Treatment Guidelines (2009), page 20, which is part of the MTUS.

#### Rationale for the Decision:

The employee was injured on 7/5/2006. The employee was initially diagnosed with a fracture of the distal radius and ulna as well with a scaphoid fracture. The most recent physical evaluation dated 7/12/2013 noted the employee's complaints included constant aching to the wrist, pain, swelling and stiffness. The notes indicate that the employee is status post right wrist fusion and examination noted moderate to severe tenderness over the radial styloid and ulna styloid. The provider noted moderate swelling of the wrist joint with a positive drop test, piano key test, Watson's test and Finkelstein's test as well as Tinel's sign. The range of motion of the right wrist revealed 0 degrees of flexion, 10 degrees of extension, and 0 degrees of radial and ulnar deviation. On manual muscle testing, the employee had 4/5 strength in the right wrist and 5/5 in the left. A recommendation was made for physical therapy for the right wrist to increase flexibility, range of motion and strength, with work conditioning to follow. The provider prescribed Norco 7.5/325 mg quantity 60 and a wrist splint/brace. A request was submitted for physical therapy for the right wrist, 3 times 4.

The MTUS Postsurgical Treatment Guidelines recommend 16 physical therapy visits over 8 weeks. The current request for physical therapy for the right wrist is not supported given that the prior number of sessions attended by the employee is not known. Additionally, the current request as stated fails to indicate the number of sessions requested for the employee to attend. Furthermore, the date of the fusion is not indicated in the notes submitted for review and there are no details in regards to the time frame from surgery to the request for physical therapy. Based on guideline criteria after the post-surgical period; the MTUS Chronic Pain Guidelines would be relevant; and there is no indication that physical therapy would have effect on functional recovery of the employee. The request for physical therapy for the right wrist, 3 times 4 **is not medically necessary and appropriate.**

**2) Regarding the request for Norco 7.5/325mg, #60:**

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), page 78, Opioids Section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 78 and 91, which are part of the MTUS.

Rationale for the Decision:

The employee was injured on 7/5/2006. The employee was initially diagnosed with a fracture of the distal radius and ulna as well with a scaphoid fracture. The most recent physical evaluation dated 7/12/2013 noted the employee's complaints included constant aching to the wrist, pain, swelling and stiffness. The notes indicate that the employee is status post right wrist fusion and examination noted moderate to severe tenderness over the radial styloid and ulna styloid. The provider noted moderate swelling of the wrist joint with a positive drop test, piano key test, Watson's test and Finkelstein's test as well as Tinel's sign. The range of motion of the right wrist revealed 0 degrees of flexion, 10 degrees of extension, and 0 degrees of radial and ulnar deviation. On manual muscle testing, the employee had 4/5 strength in the right wrist and 5/5 in the left. A recommendation was made for physical therapy for the right wrist to increase flexibility, range of motion and strength, with work conditioning to follow. The provider prescribed Norco 7.5/325 mg quantity 60 and a wrist splint/brace. A request was submitted for Norco 7.5/325mg, #60.

The MTUS Chronic Pain Medical Treatment Guidelines indicate that hydrocodone/Norco is indicated for moderate to moderately severe pain. The guidelines further detail the recommendation for the "4 A's" for ongoing monitoring of patients on opioid analgesics, with the 4 domains for monitoring indicated as analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The records submitted and reviewed indicate the employee has been prescribed Norco since at least 3/22/2013. However, the documentation lacks evidence of the employee's functional response to the medication by detailing analgesic effect or improved ability to undertake activities of daily living. The request for Norco 7.5/325mg, #60 **is not medically necessary and appropriate.**

**3) Regarding the request for a DME purchase - right wrist brace:**

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 Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11, page 272), which are part of the California 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 was injured on 7/5/2006. The employee was initially diagnosed with a fracture of the distal radius and ulna as well with a scaphoid fracture. The most recent physical evaluation dated 7/12/2013 noted the employee's complaints included constant aching to the wrist, pain, swelling and stiffness. The notes indicate that the employee is status post right wrist fusion and examination noted moderate to severe tenderness over the radial styloid and ulna styloid. The provider noted moderate swelling of the wrist joint with a positive drop test, piano key test, Watson's test and Finkelstein's test as well as Tinel's sign. The range of motion of the right wrist revealed 0 degrees of flexion, 10 degrees of extension, and 0 degrees of radial and ulnar deviation. On manual muscle testing, the employee had 4/5 strength in the right wrist and 5/5 in the left. A recommendation was made for physical therapy for the right wrist to increase flexibility, range of motion and strength, with work conditioning to follow. The provider prescribed Norco 7.5/325 mg quantity 60 and a wrist splint/brace. A request was submitted for a DME purchase – right wrist brace.

The ACOEM Guidelines indicate that splinting is recommended as an option but caution that prolonged splinting leads to weakness and stiffness and therefore is an optional treatment of any forearm, wrist or hand disorder. Moreover, the documentation submitted for review fails to detail a clear clinical rationale for the necessity of a wrist brace for this employee. Further, there are no detailed specific reasons provided in the documentation for the use of a wrist splint. The request for a DME purchase – right wrist brace **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, 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.