

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/2/2013  
Date of Injury: 2/4/2013  
IMR Application Received: 8/12/2013  
MAXIMUS Case Number: CM13-0009787

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 Orthopedic Surgery, has a subspecialty in Hand Surgery and is licensed to practice in Texas. 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 patient is a 30-year-old female who reported an injury on 02/04/2013. The mechanism of injury was not indicated in the review. Evaluation of the patient on 02/11/2013 indicated the patient had wrist pain whenever she tried to push or lift something which the patient indicated as a pinching-type pain. The patient stated she has the pain for a great length of time with progressive worsening more recently. Physical evaluation of the patient's right hand and wrist revealed tenderness to the extensor surface of the hand and wrist with flexion and extension. There were no erythema, discoloration, ecchymosis, swelling, masses, cysts, or scars noted on the wrist, hand, or fingers. There was no deformity noted as well. The patient had negative Phalen's test, negative Tinel's sign, negative Finkelstein's maneuver, and negative Allen's test, as well as negative carpal compression test. The patient had no sensory changes to light touch or pinprick. Electrodiagnostic testing was carried out on 08/21/2013 with notes indicating a normal study. MRI of the cervical spine and thoracic spine was carried out on 06/28/2013 with normal findings of the thoracic spine and evidence of 1 mm retrolisthesis of C3-4 and neutral in the extension with no evidence of stenosis and evidencing of straightening of the cervical lordosis consistent with musculoskeletal strain. Additionally, it was indicated the patient attended physical therapy sessions with the patient having been seen for her third session of therapy as of 02/28/2013.

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

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

**1. Chiropractic for bilateral shoulders, elbows, hands, and wrists is not medically necessary and appropriate.**

The Claims Administrator based its decision on the MTUS chronic pain-manipulation.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy, pgs. 58-59, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS States Manual therapy & manipulation

Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The documentation submitted for review indicates this patient has complaints of pain to the right wrist, with no recent comprehensive evaluation submitted of the patient. The most recent physical therapy note was completed on 02/28/2013 which indicated only that the patient was tolerating exercises well; however, fatigued easily with light resistance. Also, the notes indicate the patient was educated in a home exercise program. Furthermore, there was a lack of recent evaluation indicating current musculoskeletal condition of the patient to support the recommendation for chiropractic therapy. Given the above, the request for chiropractic for bilateral shoulders, elbows, hands, and wrists is not medically necessary and appropriate.

**2. Physical therapy for bilateral shoulders, elbows, hands, and wrists is not medically necessary and appropriate.**

The Claims Administrator based its decision on the MTUS chronic pain-manipulation.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, pgs. 98-99, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS states active therapy requires an internal effort by the individual to

Complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The documentation submitted for review indicates this patient last underwent physical therapy on 02/28/2013 for her third session. The notes indicate the patient was undergoing treatment for right wrist pain. Moreover, there was a lack of documentation submitted for review in the form of a recent clinical evaluation of the patient with comprehensive examination of the bilateral shoulders, elbows, hands, and wrists. Given the above, the request for physical therapy for the bilateral shoulders, elbows, hands, and wrists 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]  
[REDACTED]  
[REDACTED]

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