

## Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

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|---|-----------------|------------------------------|------------|
| <b>IMR Case Number:</b>   | CM13-0001161    | <b>Date of Injury:</b>       | 05/15/2013 |
| <b>Claims Number:</b>   | [REDACTED]      | <b>UR Denial Date:</b>       | 06/26/2013 |
| <b>Priority:</b>  | STANDARD        | <b>Application Received:</b> | 07/10/2013 |
| <b>Employee Name:</b>   | [REDACTED]      |                              |            |
| <b>Provider Name:</b>   | [REDACTED] M.D. |                              |            |
| <b>Treatment(s) in Dispute Listed on IMR Application:</b>           |                 |                              |            |
| MRI OF WRIST, IF UNIT, PHARMACOLOGICAL CONSULT & MYOFASCIAL RELEASE |                 |                              |            |

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 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:

- [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:

The claimant is a 28 year old female with a lifting injury to her right arm which was incurred on May 15, 2013. The most recent clinical progress report was dated October 3, 2013 at which time the claimant saw Dr. [REDACTED] for subjective complaints of right wrist and hand pain described as moderate in nature, sharp and throbbing, aggravated by lifting and grasping. Objectively there was spasm and tenderness to the right anterior lateral wrist at the base of the thumb, wrist range of motion was diminished, a positive Finklestein test and positive bracelet test were noted. The claimant's diagnosis was tendinitis of the right wrist and hand due to continued subjective and objective findings. A work hardening program for six sessions was recommended to increase function, and a Functional Capacity Examination was also ordered at that time, due to ongoing complaints. Work restrictions were continued to be enforced. No other treatment was noted. A prior assessment of September 4, 2013 indicated the same diagnosis and physical examination findings; there was notation that the claimant had recently completed nine sessions of physical therapy and at that time was prescribed a topical compounded cream as well as a Functional Capacity Examination and work hardening program. Treatment has also included splinting, anti-inflammatory agents, icing and work restrictions.

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

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

- 1. MRI of right wrist is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition (2004), page 272, which is part of the MTUS; and the Official Disability Guidelines (ODG), Forearm, Wrist, and Hand Chapter, MRIs, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The CA MTUS ACOEM Guidelines indicate that use of MRI is optional prior to a history examination by a qualified specialist. Official Disability Guidelines criteria allow for MRI imaging in the chronic setting when plain radiographs are equivocal and or negative and there is suspicion for tumor or Kienbock's disease. CA MTUS and ODG do not support the use of MRI as a diagnostic tool for DeQuervain's tenosynovitis. The claimant's clinical presentation, physical examination findings and current subjective complaints are highly consistent with a diagnosis of DeQuervain's tenosynovitis for which standard treatment has not included injection therapy. The claimant's diagnosis appears to be quite evident on examination and the guidelines would not support the use of an MRI as a diagnostic tool for this; as such the MRI is not recommended as medically necessary.

## **2. Multi-interferential stimulator is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 118, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on the CA MTUS Chronic Pain Guidelines multi-interferential stimulator is not supported. Interferential stimulation is only indicated in situations where first line therapeutic intervention has been utilized and failed. Interferential stimulation is not recommended as an isolated intervention. The claimant's current diagnosis and lack of treatment noted to date i.e. corticosteroid injection would not support a medical necessity for the requested interferential device for DeQuervain's tenosynovitis.

## **3. Pharmacological consultation for evaluation and dispensing of medication is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS and Official Disability Guidelines.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 7, page 127.

The Physician Reviewer's decision rationale:

Based on the CA ACOEM Guidelines referral for pharmacological consultation would not be indicated. The diagnosis appears consistent with that of DeQuervain's

tenosynovitis for which medication management would consist of antiinflammatory agents or injection of anesthetic and corticosteroid. These treatments do not appeared to have occurred over the past several months. A pharmacological consultation for dispensing of medications prior to use of initial standard methods of treatment for the current diagnosis would not be supported.

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#### **4. Myofascial release to the right wrist is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Physical Medicine, page 98, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on the CA MTUS the requested myofascial release to the right wrist is not indicated. Guidelines state that "Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries". The claimant continues to be with symptomatic findings however there is not documentation of the standard forms of conservative care such as corticosteroid injections that are highly successful in alleviating symptoms. It is not clear as to what significant benefit would be gained in this chronic setting from this passive modality; as this type of therapy is supported for short term relief in the early phases of pain treatment which is not the case here, the requested myofascial release would not be considered as medically necessary.

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.

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