

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
P.O. Box 138009  
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**Notice of Independent Medical Review Determination**

Dated: 10/30/2013

[REDACTED]

[REDACTED]

|                           |              |
|---------------------------|--------------|
| Employee:                 | [REDACTED]   |
| Claim Number:             | [REDACTED]   |
| Date of UR Decision:      | 7/3/2013     |
| Date of Injury:           | 3/28/2012    |
| IMR Application Received: | 7/29/2013    |
| MAXIMUS Case Number:      | CM13-0004301 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for right De Quervain's release surgery plus or minus tenosynovectomy/tenolysis **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for pre-operative medical clearance **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for post-operative chiropractic services, twelve (12) visits **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for post-operative coolcare cold therapy unit **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for MRI of the cervical spine **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for EMG of the right upper extremity **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for NCV of the right upper extremity **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 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/6/2013. 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 De Quervain's release surgery plus or minus tenosynovectomy/tenolysis **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for pre-operative medical clearance **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for post-operative chiropractic services, twelve (12) visits **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for post-operative coolcare cold therapy unit **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for MRI of the cervical spine **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for EMG of the right upper extremity **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for NCV of the right upper extremity **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 Orthopaedic 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.

### **Expert Reviewer Case Summary:**

This patient is a 40-year-old female who reported an injury on 03/28/2012. The documentation submitted for review indicates the patient to have multiple complaints regarding the right wrist, cervical spine, and right shoulder. Notes indicate that the patient has sought and received temporary relief from 2 prior De Quervain's injections for the right wrist, which were provided in 02/2012 and 07/2012. Notes indicate that each of these injections provided the patient approximately 3 months of relief. Other therapies for the patient have included medication management, formal therapy, and activity modification. A request for authorization dated 03/22/2013 indicated a request

for surgical intervention in the form of a De Quervain's release surgery, as well as for a supervised course of postoperative chiropractic services, and a postoperative Coolcare cold therapy unit, as well as preoperative medical clearance. The most recent physical examination of the patient's right wrist was carried on 07/29/2013, which noted subjective complaints of a flare-up of right wrist De Quervain's pain with complaints of occasional locking during repetitive typing. Notes indicated that, on objective evaluation of the right wrist, there was tenderness of the first dorsal compartment with positive Finkelstein's, and mild swelling and active locking of the right thumb. Evaluation of the right shoulder noted tenderness to palpation of the parascapular region, the upper trapezius, and the levator scapulae, with active range of motion in flexion to 105 degrees, extension 32 degrees, abduction 100 degrees, adduction 40 degrees, and internal and external rotation of 70 degrees. On evaluation of the cervical spine, there was tenderness to palpation of the paravertebral muscles bilaterally, as well as of the upper trapezius with positive axial compression signs. Subjectively, the patient had complaints of numbness and tingling travelling into the right upper extremity, emanating from the neck. Recommendation was made for the patient to undergo right wrist De Quervain's surgery and for the patient to receive authorization for acupuncture treatment to decrease pain and increase range of motion of the right wrist, as well as for treatment of the bilateral shoulders, neck and low back.

#### **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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from (Claims Administrator, employee/employee representative, Provider)
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for right De Quervain's release surgery plus or minus tenosynovectomy/tenolysis:**

##### Section of the Medical Treatment Utilization Schedule 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), 2<sup>nd</sup> Edition, (2004), Forearm, Wrist, and Hand Complaints Chapter, page 271 and Table 11-7, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Forearm, Wrist, and Hand Complaints Chapter, pgs. 270-271, which is part of the California Medical Treatment Utilization Schedule (MTUS).

##### Rationale for the Decision:

MTUS guidelines indicate that with regards to De Quervain's syndrome, the majority of patients with De Quervain's syndrome will have resolution of symptoms with conservative treatment and that, under unusual circumstances of

persistent pain at the wrist and limitation of function, surgery may be an option for treating De Quervain's tendinitis. The guidelines further recommend hand surgery consultation as indicated for patients who have red flags of a serious nature, fail to respond to conservative management, and who have clear and clinical special study evidence of a lesion that has been shown to benefit in both the short and long term from surgical intervention. Medical records submitted and reviewed indicate that the employee has undergone 2 prior De Quervain's injections with significant benefit for a period of 3 months after each injection, and that the employee has undergone extensive conservative treatments to include formal physical therapy and medication management. The criteria have been met. **The request for right De Quervain's release surgery plus or minus tenosynovectomy/tenolysis is medically necessary and appropriate.**

**2) Regarding the request for pre-operative medical clearance:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Low Back Chapter, Preoperative Electrocardiogram, Preop Lab Testing, and Preop Testing (General) sections, which is a Medical Treatment Guideline (MTG) that is not part of the California Medical Treatment Utilization Schedule (MTUS). The Expert 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 Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Preop Testing (General) section.

Rationale for the Decision:

The Official Disability Guidelines (ODG) indicate that preoperative medical clearance is often performed before surgical procedures and that these investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but are often obtained because of protocol rather than medical necessity. While the documentation submitted for review indicates that the employee has multiple complaints of pain and that the employee is recommended for De Quervain's release surgery, there is a lack of documentation indicating significant comorbidities or risk factors necessitating a preoperative medical clearance for this outpatient procedure. **The request for pre-operative medical clearance is not medically necessary and appropriate.**

**3) Regarding the request for post-operative chiropractic services, twelve (12) visits:**

Section of the Medical Treatment Utilization Schedule 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), Manual therapy & manipulation, American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition (2004), page 265 and Table 8-7, and Postsurgical Treatment Guidelines, Radial Styloid Tenosynovitis section, which is part of the California Medical Treatment

Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

MTUS guidelines indicate that postoperative therapy for De Quervain's release can be recommended as a maximum of 14 visits over 12 weeks. The guidelines further indicate that the initial course of therapy means 1 half the number of visits specified in the general course of therapy for the specific surgery. The current request for postoperative chiropractic therapy sessions for 12 visits, while within the recommendation of the general course of therapy, exceeds the recommendation of the guidelines for the initial course of therapy. **The request for post-operative chiropractic services, twelve (12) visits is not medically necessary and appropriate.**

**4) Regarding the request for post-operative coolcare cold therapy unit:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter. The Expert 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 Expert Reviewer based his/her decision on Official Disability Guidelines, Forearm, Wrist and Hand Chapter, Cold Packs section.

Rationale for the Decision:

MTUS guidelines do not specifically address cold therapy units in the postoperative phase. The Official Disability Guidelines (ODG) have a general recommendation that a cold therapy unit may be recommended postoperatively for up to 7 days. However, the guidelines with respect to treatment of the forearm, wrist, and hand, indicate that cold packs are recommended at home for local application of therapy in the first few days of acute complaints and, thereafter, applications of heat packs. **The request for post-operative coolcare cold therapy unit is not medically necessary and appropriate.**

**5) Regarding the request for MRI of the cervical spine:**

Section of the Medical Treatment Utilization Schedule 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), 2<sup>nd</sup> Edition (2004), Table 8-7 the Official Disability Guidelines (ODG), Neck Chapter, MRI section, which is a Medical Treatment Guideline (MTG) that is not part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition, (2004), Neck and Upper Back Complaints, pgs.

177-179, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

MTUS guidelines indicate that unequivocal findings which identify specific nerve compromise on neurological examination are sufficient evidence to warrant studies if symptoms persist; however, when the neurological examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Medical records submitted for review indicates the employee to have complaints regarding the cervical spine with tenderness of the paravertebral muscles bilaterally, the upper trapezius, and positive axial compression signs. However, there is a lack of clear clinical indication that the employee has undergone treatment for the neck prior to the request for MRI of the cervical spine. While notes indicate that the employee has subjective complaints of neck pain radiating to the right upper extremity with numbness and tingling, there is no clear documentation of a specific dermatomal pattern or objective clinical findings indicating a significant neural pathology. **The request for MRI of the cervical spine is not medically necessary and appropriate.**

**6) Regarding the request for EMG of the right upper extremity:**

Section of the Medical Treatment Utilization Schedule 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), 2<sup>nd</sup> Edition, (2004), Neck and Upper Back Complaints Chapter, pg. 178, Table 8-8, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Neck and Upper Back Complaints Chapter, pgs. 177-179, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

MTUS guidelines indicate that electromyography and nerve conduction velocity studies, including H-reflex tests, may help identify subtle, focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 weeks or 4 weeks. The medical records submitted for review indicates the employee to have complaints of the right shoulder with limited range of motion and tenderness to palpation of the subacromial and AC joints. Furthermore, notes indicate the employee to have findings of positive impingement signs. However, there is no documentation consistent with a neural pathology of the right upper extremity to warrant electromyographic or nerve conduction velocity studies. Furthermore, there is a lack of documentation indicating that the employee has undergone sufficient conservative treatment for the right shoulder prior to the request for electrodiagnostic studies. **The request for EMG of the right upper extremity is not medically necessary and appropriate.**

## 7) Regarding the request for NCV of the right upper extremity:

### Section of the Medical Treatment Utilization Schedule 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), 2<sup>nd</sup> Edition, (2004), Neck and Upper Back Complaints Chapter, pg. 178, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Neck and Upper Back Complaints Chapter, pgs. 177-179, which are part of the California Medical Treatment Utilization Schedule (MTUS).

### Rationale for the Decision:

MTUS guidelines indicate that electromyography and nerve conduction velocity studies, including H-reflex tests, may help identify subtle, focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 weeks or 4 weeks. The documentation submitted for review indicates the employee to have complaints of the right shoulder with limited range of motion and tenderness to palpation of the subacromial and AC joints. Furthermore, notes indicate the employee to have findings of positive impingement signs. However, there is no documentation consistent with a neural pathology of the right upper extremity to warrant electromyographic or nerve conduction velocity studies. Furthermore, there is a lack of documentation indicating that the employee has undergone sufficient conservative treatment for the right shoulder prior to the request for electrodiagnostic studies. **The request for NCV of the right upper extremity 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,

Paul Manchester, MD, MPH  
Medical Director

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

/ldh

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.