

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/18/2013
Date of Injury:	6/18/2013
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005796

- 1) MAXIMUS Federal Services, Inc. has determined the request for **1 MRI of the right wrist** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 MRI of the right thumb** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **1 x-ray series of the left knee (AP and lateral)** is **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **12 aquatic therapy sessions** is not **medically necessary and appropriate**.

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/26/2013. 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 **1 MRI of the right wrist** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 MRI of the right thumb** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **1 x-ray series of the left knee (AP and lateral)** is **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **12 aquatic therapy sessions** 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 Preventive Medicine and Occupational Medicine, 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:**

All medical, insurance, and administrative records provided were reviewed.

The applicant is a represented [REDACTED] employee who has filed a claim for chronic wrist, thumb and knee pain reportedly associated with an industrial injury of June 18, 2008.

Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; attorney representation; a left total knee arthroplasty; wrist brace; and apparent diagnosis with bilateral thumb CMC arthrosis and right radial tunnel syndrome. In the utilization review report of July 19, 2013, the claims administrator non-certified MRI of the wrist and thumb. A series of Synvisc injections were certified while knee X-rays were non-certified. Aquatic therapy was partially certified.

In a July 2, 2013 progress note, it is suggested that applicant reports progressively worsening left knee pain with an unsteady gait. The applicant is using a cane. The applicant reports that the hand and wrist symptoms have increased as a result of using the cane. The applicant is dissatisfied with the left total knee arthroplasty, it is stated.

The applicant exhibits marked patellofemoral crepitation about the right knee with an effusion and full range of motion. The applicant is asked to obtain an MRI of the right wrist and CMC joint of the right thumb. Synvisc injections and a left knee x-ray are endorsed.

### **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
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request for 1 MRI of the right wrist:**

#### 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, Forearm, Wrist, and Hand (Acute and Chronic), which is not part of the 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 American College of Radiology (ACR) guidelines ([http://www.acr.org/Quality-Safety/Appropriateness-Criteria/Diagnostic/~media/ACR/Documents/AppCriteria/Diagnostic/ChronicWristPain.pdf](http://www.acr.org/Quality-Safety/Appropriateness-Criteria/Diagnostic/~/media/ACR/Documents/AppCriteria/Diagnostic/ChronicWristPain.pdf)).

#### Rationale for the Decision:

The American College of Radiology Guidelines indicates that plain film x-rays should be the initial imaging study of choice in any individual with chronic hand or wrist pain. The guidelines also indicate that X-rays can generally establish a specific diagnosis of arthritis, and MRI imaging can be employed in those individuals in whom first line plain films are negative and/or non-diagnostic. The medical records provided for review indicate that the employee may have had plain films at some point in the remote past, which previously establish the diagnosis of hand/wrist/carpometacarpal (CMC) joint arthritis. Therefore, if the diagnosis of hand and wrist arthritis has already been made clinically and/or radiographically, then the MRI imaging is not needed. **The request for one (1) MRI of the right wrist is not medically necessary and appropriate.**

### **2) Regarding the request for 1 MRI of the right thumb:**

#### 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, Forearm, Wrist, and Hand (Acute and Chronic), which is not part of the 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 American College of Radiology (ACR) guidelines (<http://www.acr.org/Quality-Safety/Appropriateness-Criteria/Diagnostic/~media/ACR/Documents/AppCriteria/Diagnostic/ChronicWristPain.pdf>).

Rationale for the Decision:

The American College of Radiology Guidelines indicates that plain film x-rays should be the initial imaging study of choice in any individual with chronic hand or wrist pain. The medical records provided for review do not indicate when or if the employee previously underwent x-ray studies of the hand and/or wrist. The medical records indicate that the diagnosis of CMC joint arthritis has been established; therefore, MRI imaging is not recommended. **The request for one (1) MRI for the right thumb is not medically necessary and appropriate.**

**3) Regarding the request for 1 x-ray series of the left knee (AP and lateral):**

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) Guidelines, Chapter 13 (Knee Complaints) (2004), page 343.

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 American College of Radiology (ACR) guidelines (<http://www.acr.org/Quality-Safety/Appropriateness-Criteria/Diagnostic/~media/ACR/Documents/AppCriteria/Diagnostic/ChronicWristPain.pdf>).

Rationale for the Decision:

The American College of Radiology Guidelines indicates that radiographs are the standard method for evaluating loosening and/or infection following total knee arthroplasty. The medical records provided for review indicate that the employee has ongoing complaints of knee pain following a total knee arthroplasty. Plain film imaging to try and determine the source of the employee's complaints, meets guideline criteria. **The request for one (1) x-ray series of the left knee (AP and lateral) is medically necessary and appropriate.**

**4) Regarding the request for 12 aquatic therapy sessions:**

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 (May 2009), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 22 and 99, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that aquatic therapy is recommended in those individuals in whom reduced weight-bearing is desirable. The guidelines also indicate that physical medical treatment frequency should decrease over time from 3 visits per week to 1 or less with the goal of a self-directed home exercise program. The medical records provided for review indicate that nine sessions of aquatic therapy were previously certified, and the request for twelve (12) sessions would not meet guideline criteria. **The request for twelve (12) aquatic therapy sessions 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

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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.