

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/23/2013
Date of Injury:	4/9/2012
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007728

- 1) MAXIMUS Federal Services, Inc. has determined the request for **right wrist brace is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **purchase interferential unit with hot and cold pads is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **purchase left wrist brace is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/11/2013. 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 wrist brace is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **purchase interferential unit with hot and cold pads is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **purchase left wrist brace 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 claimant is a represented [REDACTED] employee who has filed a claim for chronic neck pain, chronic mid back pain, chronic low back pain, bilateral shoulder pain, and bilateral hand pain reportedly associated with an industrial injury of April 9, 2012.

Thus far, the claimant has been treated with the following: Analgesic medications; adjuvant medications; topical applications of heat and cold; transfer of care to and from various providers in various specialties; unspecified amounts of physical therapy; electrodiagnostic testing of the bilateral upper extremities of October 18, 2012, interpreted as normal; largely negative x-rays of the wrists and hands; and work restrictions. It does not appear that the applicant has returned to work with limitations in place.

In a Utilization Review Report of July 23, 2013, the claims administrator denied a request for wrist braces and interferential stimulation.

A handwritten July 16, 2013 progress note is difficult to follow, notable for multifocal complaints of pain about the neck, mid back, low back, bilateral shoulders, and bilateral wrists. The applicant is asked to consult an orthopedist, obtain magnetic resonance imaging (MRI) imaging, pursue eight sessions of physical therapy, obtain extracorporeal

shockwave therapy, obtain a functional capacity evaluation, and return to work with limitations in place.

An earlier March 1, 2013 note diagnosed the applicant with an early arthritis in both CMC joints.

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 right wrist brace :

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), Forearm, Wrist, and Hand, which is not part of the MTUS. The Claims Administrator also cited the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) pgs pages 271-273, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) pgs pages 271-273, which is part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM Guidelines indicate that maximizing activities is imperative once red-flags have been ruled out. Any limitations placed on hand, forearm, or wrist activities should not interfere with total body activity. The medical records provided for review do not show evidence that the employee has a diagnosis of hand or wrist fracture for which splinting would be recommended. **The request for right wrist brace is not medically necessary and appropriate.**

2) Regarding the request for purchase interferential unit with hot and cold pads :

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. The Claims Administrator also cited the Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS), pages 120, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 120, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that a one-month trial of an interferential stimulator would be appropriate in those individuals in whom pain is ineffectively controlled owing to failure of analgesic medications, a history of substance abuse that would make provision of analgesic medications unwise, and/or history of medication side effects that led to poor pain control. The medical records provided for review do not show evidence of oral analgesic intolerance and/or failure or a history of substance abuse. In addition, the medical records do not show evidence of a prior successful one-month trial of the interferential stimulator. **The request for purchase interferential unit with hot and cold pads is not medically necessary and appropriate.**

3) Regarding the request for purchase left wrist brace :

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), Forearm, Wrist, and Hand, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) pgs pages 271-273, which is part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM Guidelines indicate that maximizing activities is imperative once red-flags have been ruled out. Any limitations placed on hand, forearm, or wrist activities should not interfere with total body activity. The guidelines also indicate that prolonged splinting is not recommended. The medical records provided for review do not show evidence that the employee has a diagnosis of hand or wrist fracture for which splinting would be recommended **The request for purchase left 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th 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.