

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

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Dated: 12/27/2013

<b>IMR Case Number:</b>	CM13-0008415	<b>Date of Injury:</b>	5/11/2013
<b>Claims Number:</b>	██████████	<b>UR Denial Date:</b>	7/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	8/6/2013
<b>Employee Name:</b>	████████████████████		
<b>Provider Name:</b>	████████████████████		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>	73221, 97145, S5001		

DEAR ██████████

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, ██████████ ██████████

## 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 Physical Medicine and Rehabilitation 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 date of injury in this case is 05/11/2013 with the mechanism of injury that the patient was transferring another individual and was struck in the left hand. Diagnoses have included left shoulder sprain with possible impingement syndrome, left wrist sprain with tendinitis, possible posttraumatic de Quervain's disease, and psychological sequelae. A prior reviewer notes that no diagnostics have been provided to the reviewer and that at the time of that review, the carrier had not yet accepted the claim for specific body parts. That reviewer noted that Dendracin was not documented as medically necessary and that a red flag has not been documented to support MRI of the wrist and that a diagnosis had not clearly been established yet regarding the wrist to support an indication for physical therapy.

The primary treating physician's initial orthopedic report of 07/02/2013 is very detailed and outlines this patient's usual work lifting objects weighing up to 25 pounds frequently or up to 100 pounds occasionally as a Certified Nursing Assistant. That note outlines the patient's injury when preparing to transfer a patient, the patient's brother grabbed and pulled on her left arm at the wrist and struck her on the left hand. That reviewer diagnosed the patient with left shoulder sprain and strain with possible impingement syndrome, left wrist sprain and strain with tendinitis, possible posttraumatic de Quervain's disease of the left wrist, and psychological sequelae of the industrial injury. Range of motion was globally reduced in the left wrist. Grip strength was 4 kg on the right and 200 kg on the left in a patient who is right-hand dominant. The treating provider recommended physical therapy as well as symptomatic medications and analgesic ointments and also recommended an MRI of the left wrist to rule out internal derangement.

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

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

#### **1. Dendracin ointment is not medically necessary and appropriate.**

The Claims Administrator based its decision on the MTUS, Pain, Topical Analgesics.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines Section on Topical Analgesics, Page 111, states, "The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it would be useful for the specific therapeutic goal required." The medical records at this time do not provide a rationale as to why this patient requires this specific topical medication. The records and guidelines do not support this request. This request is not medically necessary.

## **2. Physical therapy is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Physical Medicine, pages 98-99, which are part of the MTUS.

The Physician Reviewer's decision rationale:

The Section on Physical Medicine, Page 98-99 states, "Active therapy requires an internal effort by the individual to complete a specific exercise or task...allow for fading of treatment frequency plus active self-directed home Physical Medicine." A prior reviewer states that the records did not contain a specific diagnosis. The records currently available do provide a specific diagnosis. A doctor's first report states the diagnoses of a wrist sprain and a cervical sprain. Proposed treatment at that time is for physical therapy 2 times a week for 6 weeks. The Physical Medicine Guideline quoted above does support physical therapy although recommends "9-10 visits over 8 weeks" for myalgia unspecified. It may be helpful for the provider to resubmit a request for fewer sessions initially or to support a rationale as to why 12 visits are indicated. Again, the guidelines to support an indication for wrist physical therapy in general but not for 12 sessions as have been requested at this time. Therefore, the physical therapy visits 2 times a week for 6 weeks as requested are not medically necessary.

## **3. MRI of the left wrist is not medically necessary and appropriate.**

The Claims Administrator based its decision on the 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), Chapter 11, page 269, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines, Chapter 11 Wrist, Page 269, discusses "ability of various techniques to identify and define forearm, wrist, and hand pathology." That guideline recommends MRI imaging in very specific instances such as to rule out carpal tunnel syndrome or infection, which are not discussed as potential diagnoses at this time. The medical records in this case are nonspecific in discussing this request to rule out internal derangement of the wrist. Overall the records and guidelines at this time do not support the request for an MRI of the wrist. This should be noncertified.

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