

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
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(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the request for magnetic resonance imaging (MRI) of right wrist has been **declared ineligible because the Claims Administrator has not accepted liability for the claim.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for X-ray of right wrist has been **declared ineligible because the Claims Administrator has not accepted liability for the claim.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for magnetic resonance imaging (MRI) of thoracic spine has been **terminated because it has previously been approved and performed.**
- 4) MAXIMUS Federal Services, Inc. has determined the X-ray of thoracic spine performed on 2/6/2013 was **medically necessary and appropriate. However, a second X-ray of thoracic spine is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 4/3/2013 disputing the Utilization Review Denial dated 4/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 4/23/2013. 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 magnetic resonance imaging (MRI) of right wrist has been **declared ineligible because the Claims Administrator has not accepted liability for the claim.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for x-ray of right wrist has been **declared ineligible because the Claims Administrator has not accepted liability for the claim.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for magnetic resonance imaging (MRI) of thoracic spine has been **terminated because it has previously been approved and performed.**
- 4) MAXIMUS Federal Services, Inc. has determined the x-ray of thoracic spine performed on 2/6/2013 was **medically necessary and appropriate. However, a second X-ray of thoracic spine is not medically necessary and appropriate.**

Medical Qualifications of the Professional 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 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 professional 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.

Case Summary:

Disclaimer: The Claims Administrator failed to include a case summary in the utilization review denial. After review of the submitted documents, the MAXIMUS Professional Reviewer stated the case summary as:

The patient initially reported pain on 2/6/13. The Doctor's First Report notes that the patient lifted a roll of wire and felt pain in his right upper back. It was noted to be intermittent, mild to moderate, sharp pain in the back, exacerbated by movement, and lessened by rest. Exam was consistent with decreased lumbar range of motion. There were no sensory or motor deficits. Straight leg raise and special tests were all negative. The patient was diagnosed with thoracic sprain. The patient was returned to work on 2/7/13 with limited use of the right hand.

On 2/6/13 a Thoracic spine X-ray showed small spurs at several thoracic interspaces. There was no fracture or subluxation.

On 2/26/13, authorization for 6 chiropractic visits was granted. The patient was cleared to return to work on 3/15/13 with no restrictions. On 3/25/13, authorization for MRI of the thoracic spine was granted. On 4/1/13, the requests for MRIs and X-rays of the right wrist and thoracic spine were denied as medical reports were not available. On 4/5/13, an MRI of the right wrist showed a tear of the triangular fibrocartilage complex (TFCC) with secondary fluid crossover into the distal radioulnar joint. There was an effusion at the first carpometacarpal joint. Ganglion cysts at the volar surface of the distal radius and dorsal surface of the distal capitate. A thoracic spine MRI at that time showed broad based disc protrusion with mild impression on the thecal sac at T2-3, T3-4. There were small bulges at T4-5 and T5-6. There was a small right central disc protrusion at T6-7.

The patient was discharged from [REDACTED] on 4/19/13 due to failure to keep consecutive appointments on 3/28/13, 4/11/13 and 4/18/13.

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 for Independent Medical Review
- Utilization Review Vendor Referral Form by [REDACTED] (dated 3/25/13)
- Utilization Review Documentation by [REDACTED] (dated 3/26/13 through 4/2/13)
- Notices of Treatment Authorization by [REDACTED] (dated 2/26/13 through 3/26/13)
- Radiologist Report by [REDACTED] (dated 2/6/13)
- Employee's Medical Record by [REDACTED] (dated 3/13/13)
- Employee's Medical Records by [REDACTED] (dated 3/22/13 and 4/5/13)
- Employee's Chiropractic Treatment Notes by [REDACTED] (dated 3/5/13 through 3/15/13)
- Employee's Patient Status Report by [REDACTED] [REDACTED] (dated 3/22/13)
- Employee's Physical Therapy Initial Evaluation by [REDACTED] (dated 3/25/13)
- Employee's Medical Records by [REDACTED] (dated 2/6/13 through 4/19/13)
- Official Disability Guidelines – Back Chapter and Forearm/Wrist/Hand Chapter: X-ray and MRI Sections
- MTUS – Chronic Pain Treatment Guidelines: Page 6

1) Regarding the request for magnetic resonance imaging (MRI) of right wrist:

Upon review by the California Department of Industrial Relations, Division of Workers' Compensation, it was determined in a notice dated 4/16/2013 that the Claims administrator has not accepted liability for this claim. MAXIMUS is not able to perform an independent medical review if liability is in dispute. **The request for MRI of right wrist has been declared ineligible.**

2) Regarding the request for X-ray of right wrist:

Upon review by the California Department of Industrial Relations, Division of Workers' Compensation, it was determined in a notice dated 4/16/2013 that the Claims administrator has not accepted liability for this claim. MAXIMUS is not able to perform an independent medical review if liability is in dispute. **The request for X-ray of right wrist has been declared ineligible.**

3) Regarding the request for magnetic resonance imaging (MRI) of thoracic spine:

Upon review of the Claims Administrator's documentation and medical records provided, it was determined that this claim has already been approved and the service has already been provided. In a notice dated 3/25/2013, the Claims Administrator authorized the MRI of thoracic spine. In a separate notice dated 3/29/2013, the Claims Administrator reconfirmed authorization of the MRI of thoracic spine. An MRI report from [REDACTED] dated 4/5/2013 was submitted with the employee's medical records. **The request for MRI of thoracic spine has been terminated based on a change of circumstance. This Final Determination serves as notice to the Interested Parties of the termination of the request for IMR, based on the noted change of circumstance.**

4) Regarding the request for X-ray of thoracic spine:

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

The Claims Administrator did not indicate which guideline(s) were relied upon. The utilization review denial letter stated that the reason for non-certification was lack of medical information. The provider relied upon the Official Disability Guidelines (ODG) (2009) – Back Chapter; Forearm/Wrist/Hand Chapter and Chronic Pain Medical Treatment Guidelines (2009) – Page 6, of the California Medical Treatment Utilization Schedule (MTUS). The Professional Reviewer found that the cited guidelines do not directly address thoracic spine x-rays. The Professional Reviewer found the MTUS Section 9792.23.5 – Low Back Complaints (Pages 303-305) more relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee had mid back pain after lifting a roll of wire. This is consistent with thoracic strain. MTUS Section 9792.23.5 – Low Back Complaints (Pages 303-305) states that lumbar spine X-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, spine X-rays may be appropriate when the physician believes it would aid in patient management. The employee completed a thoracic X-ray on 2/6/2013 based on his initial presentation and complaint of upper back pain at the time of injury.

The utilization review documents by [REDACTED] dated 4/1/2013 and 4/2/2013, were not clear as to whether this was a retrospective request to determine the medical necessity of the X-ray performed on 2/6/2013, or if it was a prospective request to determine if a future X-ray is medically necessary and appropriate. The Professional Reviewer determined that only the thoracic X-ray on 2/6/2013 was appropriate based on the MTUS. **The X-ray of thoracic spine performed on 2/6/2013 was medically necessary and appropriate. However, a second X-ray of thoracic spine 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;

Richard C. Weiss, MD, MPH, MMM, PMP
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.