

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested magnetic resonance imaging (MRI) of the right hip **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested additional physical therapy 3 times a week fro 2 weeks **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 4/24/2013 disputing the Utilization Review Denial dated 4/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 5/30/2013. 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 requested magnetic resonance imaging (MRI) of the right hip **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested additional physical therapy 3 times a week fro 2 weeks **is 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 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 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated April 10, 2013

“MRI of the sacrum coccyx without contrast dated 03/14/13 reveals no evidence of fracture of sacrum or coccyx.

MRI of the lumbar spine without contrast dated 03/14/13 reveals lumbar spondylosis at L1-2 through L5-S1 discs. At L4-5, there is 4mm broad based posterior disc protrusion. At L5-S1, there is 4mm posterior osteophyte disc complex.

PR-2 dated 03/19/13 indicates that the claimant states lower back is feeling better than when the claimant first came in. On exam, range of motion of the back is limited by pain. Forward flexion is 45 degrees. There is tenderness to posterior SI joint on the right. There is tenderness to palpate long the right paravertebral lumbar spine. Straight leg raise is positive on the right. Provider recommends MRI and referral to neurosurgeon for evaluation and treatment. The claimant has been instructed to return to modified work on 03/19/13 with restrictions to no lifting over 10 pounds, no overhead work, no stooping and bending, no prolonged sitting, and must have at least a 10 minute break every hour to stretch.

PR-2 dated 03/27/13 indicates that the claimant complains of lower back and right hip pain. It provokes with walking and bending and palliates with lying and hot pads. The pain is described as sharp stabbing pain with movement and with sitting a dull and

constant pain. The pain radiates from the lower back to right leg. The pain is rated 2/10 with sitting and 8/10 with wrong movement. There is pain with long movements throughout the day. Examination of the lumbar spine reveals right-sided antalgic gait. Range of motion is full and flexion is with mild pain. Extension is 5 degrees with severe pain and rotation and bending is full. There is marked tenderness in the right groin, right greater trochanter, right SI joint, and right paraspinal lumbosacral. There is decreased strength in the right lower extremity due to right hip and growing pain essentially in all planes. Decreased sensation is noted in the right L5 and S1 dermatome. Deep tendon reflex is absent in the right Achilles tendon. Fabere is grossly positive on the right side causing severe shooting pain into the right groin. Straight leg raise is positive on the right lower extremity reproducing radiating pain down the posterior and lateral thigh and buttock. Provider recommends MRI of the right hip to evaluate for internal derangement and continued physical therapy for the right hip 3 times per week for an additional 2 weeks. The claimant has been instructed to return to modified work on 03/27/13 with restrictions to no standing/walking over 1 hour, no stooping and bending, no climbing and no commercial driving for now as well as allow the claimant to sit and stand as tolerated to control pain.

Review of claim notes that the claimant has completed 6 visits of physical therapy.”

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:

- Two Applications for Independent Medical Review (received 4/24/13)
- Utilization Review Determination from [REDACTED] (dated 4/10/13)
- No medical records were submitted for this review

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

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Hip & Pelvis Chapter (Official Disability Guidelines (ODG), 11th Edition (web), (2012), which is a Medical Treatment Guideline (MTG) not in the Medical Treatment Utilization Schedule (MTUS) and is the most recent version of the MTG. The California MTUS was not applicable and relevant to the clinical circumstance of the employee. The provider did not provide an evidence basis with his/her Request For Authorization. The Expert Reviewer agreed with found the referenced MTG used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a non-specific injury on 2/7/13. An MRI without contrast dated 3/14/13 showed no evidence of fracture of the sacrum or coccyx. An MRI of the lumbar spine on the same date revealed lumbar spondylosis at L1-2 through L5-S1 discs. At L4-5 there was a 4mm broad based posterior disc protrusion. At L5-S1 there was a 4mm posterior osteophyte disc complex. An examination conducted on 3/19/13 revealed range of motion was limited by pain,

forward flexion of 45 degrees, tenderness to the posterior SI joint on the right, tenderness on the right paravertebral lumbar spine and straight leg raise was positive. On 3/27/13 the employee continued to experience pain in the low back and right described as sharp/stabbing on movement and dull/constant on sitting, which radiated down the right leg. There was decreased strength in the right lower extremity due to right hip pain. The employee returned to modified work on 3/27/13 and an MRI of the right hip and additional six sessions of physical therapy were requested.

California MTUS/ACOEM guidelines do not address hip imaging. ODG's states, 'Indications for imaging -- magnetic resonance imaging: osseous, articular or soft-tissue abnormalities, osteonecrosis, occult acute and stress fracture, acute and chronic soft-tissue injuries, tumors.' Based on the utilization review summary the employee's hip pain appeared to be referred and radicular in nature. The employee had no corroborative range of motion or strength deficits noted in the hip flexors that cannot be explained by the untreated radiculopathy. There were no clinical presentation findings noted consistent with evidence of avascular necrosis, osteonecrosis occult acute and stress fracture, acute and chronic soft-tissue injuries or tumor. The request for a MRI of the right hip **is not medically necessary and appropriate.**

2) Regarding the request for additional physical therapy 3 times a week for 2 weeks:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Low Back Chapter (Official Disability Guidelines (ODG), 11th Edition (web), (2012), which is a Medical Treatment Guideline (MTG) not in the Medical Treatment Utilization Schedule (MTUS) and is the most recent version of the MTG. The provider did not provide an evidence basis with his/her Request For Authorization. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg 98-99, of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a non-specific injury on 2/7/13. MRIs without contrast dated 3/14/13 were reported as no evidence of fracture of the sacrum or coccyx; lumbar spondylosis at L1-2 through L5-S1 discs, at L4-5 there was a 4mm broad based posterior disc protrusion, and at L5-S1 there was a 4mm posterior osteophyte disc complex. An examination conducted on 3/19/13 revealed forward flexion of 45 degrees, tenderness to the posterior SI joint on the right, tenderness on the right paravertebral lumbar spine and straight leg raise was positive. On 3/27/13 the employee was still experiencing low back and right hip pain described as sharp, stabbing pain on movement and dull, constant pain on sitting, radiating down the right leg. There was decreased strength in the right lower extremity due to right hip pain. The employee returned to modified work on

3/27/13 and an MRI of the right hip and additional six sessions of physical therapy were requested.

The clinical summary provided indicated evidence of radiculopathy as noted by decreased strength in the right lower extremity and decreased sensation in the L5-S1 distribution. MRI of the lumbar spine revealed disc protrusion suggesting the pain experienced was neuropathic in nature, which was supported by a positive straight leg raise test. Treatment for radiculopathy requires a trial of medication, therapy and then failing those, interventional pain management. Regarding therapy, MTUS Chronic Pain Guidelines support 8-10 therapy visits for exacerbations of chronic pain. Therefore, the request for additional physical therapy 3 times a week for 2 weeks **is 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.