
Notice of Independent Medical Review Determination

Dated: 8/28/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	5/17/2013
Date of Injury:	2/28/2013
IMR Application Received:	5/28/2013
MAXIMUS Case Number:	CM13-0000487

- 1) MAXIMUS Federal Services, Inc. has determined the request for lumbar spine MRI is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/28/2013 disputing the Utilization Review Denial dated 5/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/15/2013. 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 a lumbar spine MRI 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 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 May 17, 2013

“The patient is a 31-year-old female who sustained an injury on 02/28/13. It was noted in the workers’ compensation initial orthopaedic evaluation by Dr. [REDACTED] dated 3/12/13; the patient was initially treated with chiropractic. The patient reported pain on the bilateral shoulders, arms, and neck; the pain was worse on the right side than the left; there was occasional numbness in the right arm; throbbing and burning sensation in the right armpit, shoulder, upper arm, forearm, and hand. The patient also complained of low back pain. Physical examination of the cervical spine revealed normal cervical lordosis, spinous processes were normally aligned, no pain with palpation of the spinous processes, palpation of the paraspinal muscles revealed no spasms, full range of motion without pain, and had a normal thoracic and lumbar spine range of motion. Sensation was intact to light touch and pinprick in all dermatomes of the bilateral upper extremities, negative Tinsel’s test at both wrist, Phalen’s test seems to cause some numbness in the right hand. Recommendations included trial physical therapy for neck and back and for the right upper extremity. On 03/26/13, the patient was seen again by Dr. [REDACTED] reported that her right buttock and leg pain had worsened with tingling as well as shoulder and right sided neck pain and back. It was noted that nerve conduction studies of the upper and lower extremities was done but no electrodiagnostic testing. The provider requested the physical therapy for the neck, back, right shoulder, and arm, but has not yet authorized. In the progress noted dated 05/13/13, the patient reported continued tingling and burning sensation occurring into her bilateral shoulders and back area, was unable to sit for over 30 minutes due to constant pain. It was noted that the patient had attended 12 sessions of physical therapy without improvement and still attending chiropractic sessions. The provider was requesting for MRI of the cervical, thoracic, and lumbar spine.”

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 (dated 5/28/2013)
- Utilization Review from [REDACTED] (dated 5/17/2013)
- Medical Records from [REDACTED] (dated 2/28/13)
- Medical Records from [REDACTED] (dated 3/12/13-6/26/13)
- Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 pg 303

1) Regarding the request for MRI:

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 Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12, pg. 303, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 2/28/13 to the bilateral shoulders, arms, and neck. Medical records provided and reviewed indicate treatment has consisted of physical therapy, chiropractic treatment, oral medications, and an EMG. The medical record from 3/12/13 notes lumbar symptoms consistent with a lumbar strain, and the medical report of 5/7/13 does not document any possible radicular symptoms. The request is for a MRI of the lumbar spine.

ACOEM guidelines support an MRI of the lumbar spine in instances of where the neurologic examination shows sufficient or unequivocal findings of radicular pain. The medical records reviewed do not indicate any subjective or objective findings of radicular pain or paresthesias down the lower extremities which meet the criteria for a lumbar MRI. The request for a lumbar spine MRI **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

/dl

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.