

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/2/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/32013
Date of Injury:	6/17/1998
IMR Application Received:	7/22/2013
MAXIMUS Case Number:	CM13-0002263

- 1) MAXIMUS Federal Services, Inc. has determined the request for an MRI of the lumbar spine **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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 an MRI of the lumbar spine **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 Internal 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.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013:

“Nurse Clinical summary: DOI:6/17/98, claimant c/o right sided shoulder pain that radiates to her upper trapezius/neck and also c/o low back pain that radiates to her left leg, rates pain at 8-9/10 on a scale of 0-10, upon physical exam tenderness over the lumbar paraspinal muscles, straight leg raise is mildly positive on the left and negative on the right and decreased light to touch throughout the left lower extremity.”

### **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 (received 7/22/2013)
- Utilization Review Determination from [REDACTED] (dated 7/3/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

### **1) Regarding the request for an MRI of the lumbar spine:**

#### Medical Treatment Guideline(s) 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, 2<sup>nd</sup> Edition, (2004), Chapter 12, Low Back Complaints, Table 12-8, which is part of the California 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 was injured on 6/17/1998 and has experienced right side shoulder pain with radiation to the upper trapezius/neck and low back pain with radiation into the left leg. The employee rates pain as 8 or 9 out of 10. On physical examination, the provider noted tenderness over the lumbar paraspinal muscles, mildly positive straight leg raise on the left and decreased sensation in the left lower extremity. A request was submitted for an MRI of the lumbar spine.

The ACOEM Guidelines indicate that unequivocal objective findings that identify specific nerve compromise on neurologic examination are sufficient evidence to warrant imaging in patients who did not respond to treatment. The records submitted and reviewed document findings consistent with specific nerve compromise on neurologic testing which warrants further evaluation with imaging. The request for an MRI of the lumbar spine **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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/sab

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.