

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/4/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/15/2013
Date of Injury:	6/6/2012
IMR Application Received:	7/24/2013
MAXIMUS Case Number:	CM13-0003007

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

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 request for MRI scan of the thoracic spine **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 Occupational 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.

### **Expert Reviewer Case Summary:**

The patient is a female with a DOI of 6/6/2012 who fell on the floor and hit her back against a toilet landing on her buttocks. The patient has been complaining of low back pain with radiation through her legs. She also has pain in her mid to upper back which radiates from her low back. She has had PT without relief. There was an xray of the mid back previously which did not show any fracture, but did show abnormal straightening of the thoracic spine. She has deep palpation tenderness across her paraspinal muscle and scapular region.

### **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 of Independent Medical Review (received 7/24/13)
- Utilization Review Determination from [REDACTED] (dated 7/15/13)
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request for MRI scan of the thoracic spine:**

#### Section of the Medical Treatment Utilization Schedule 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), Chapter 8, pages 177-178, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also based its decision on the Official Disability Guidelines (ODG), Neck and Upper Back Chapter, MRI section, which is a

medical treatment guideline that is not part of the MTUS. Additionally, the Claims Administrator based its decision on Canale: Campbell's Operative Orthopedics, 10<sup>th</sup> Edition, Chapter 39 – Lower Back Pain and Disorders of Intervertebral Discs. The Expert Reviewer based his/her decision on ACOEM, Chapter 8, pages 177-178. The Expert Reviewer also based his/her decision on the ODG section used by the Claims Administrator.

Rationale for the Decision:

ACOEM indicates that cervical and upper back MRIs can be done if there has been a physiological insult. There is no evidence of such an insult. The ODG recommends an MRI if there is thoracic spine trauma and a neurological deficit. The clinical records provided and reviewed do not indicate neurological deficit and there is no evidence provided to state otherwise. The guideline criteria are not met. The request for an MRI scan of the thoracic spine **is not medically necessary or 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

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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.