

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 10/23/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/16/2013
Date of Injury:	11/9/1995
IMR Application Received:	8/26/2013
MAXIMUS Case Number:	CM13-0003913

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

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. 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 not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a CT scan of the lumbar spine **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The 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 determination dated 7/16/2013:

MRI of the lumbar spine high resolution with 3D reformations dated 03/26/13 reveals multilevel degenerative disc disease and degenerative joint disease with some mild central canal encroachment at L2-L3 and L3-L4 levels but no central nerve root impingement. Multilevel degenerative disc disease with multiple areas of disc protrusions and osteophytic ridging do cause moderate to moderately severe neural foraminal narrowing on the left at L2-L3 and L3-L4 levels with some abutment of the undersurface of the exiting nerve root at L3-L4, but no definite displacement or impingement. There is also some near abutment within the left lateral recess at the same levels but no definite displacement or impingement is seen within the left lateral recess therefore definitive source for the left-sided radicular symptoms is not forthcoming from this exam. There is relatively severe neural foraminal narrowing on the right at L4-L5 with imprint of the nerve root within the right neural foramen at L4-L5. This could be a source for right-sided radicular symptoms.

PR-2 dated 04/06/13 indicates that the claimant still complains of pain in the lumbar spine with range of motion and activity. There is increased low back pain with weight bearing. Examination of the lumbar spine reveals stiffness, pain with range of motion and positive straight leg raise on the right. The claimant is unable to walk more than one block. The provider recommends consultation with MD and kinesiio tape.

Initial comprehensive spine consultation report dated 06/03/13 indicates that the claimant sustained injuries to the neck and lower back on 11/09/95 while working as a flight attendant. The pain began approximately 16 years ago. The claimant underwent hip replacement on 2004 and two more hip replacements since then. The claimant has had a series of three epidural injections which did not provide any relief. The claimant received acupuncture kinesiio tape and magnet treatments that helped with range of motion and mobility. Currently, the claimant experiences daily pain and discomfort in the lower back rated at 6-8/10. The pain can be aggravated depending on the activity of the day. There is numbness and tingling down both legs and a pinching sensation. The pain in the lower back is 30-70 percent and in the legs is 30 percent, mainly the left leg. The claimant also complains of neck rated at 6-8/10. The claimant reports with activities of daily living.

The claimant drinks one drink a day but denied the consumption of drugs or tobacco. The claimant reports that everything has become progressively worse. X-ray of the lumbar spine reveals significant scoliotic deformity. There is a lateral subluxation and spondylolisthesis. These are primarily centered on L3-L4 and L4-L5 with significant degeneration at L5-S1 as well. Examination was extremely limited secondary to discomfort. The claimant did have significant sensory abnormalities bilaterally in the L4, L5 and S1 dermatomes. The motor strength is approximately grade 4/5 although difficult to assess due to discomfort. The provider states that pain has become progressively worse and opines that the claimant will require surgical intervention in the form of anterior and posterior fusion to address significant degenerative changes and levoscoliosis. The claimant has leg length discrepancy. The provider recommends a new MRI and CT scan of the lumbar spine for surgical planning purpose.

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 7/26/2013)
- Utilization Review Determination from [REDACTED]
- No medical records were provided timely by the Claim Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for an MRI 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 Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12, pages 303-305), which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Low Back Chapter, MRI section, which is a medical treatment guideline that is not part of the MTUS. 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 11/9/1995 and presents with lumbar spine pain. The employee has been diagnosed with displacement cervical disc without myelopathy and displacement thoracic disc without myelopathy. An initial comprehensive spine consultation dated 6/3/2013 noted daily pain and discomfort to the low back rated at 6/10 to 8/10. The provider documented x-rays of the lumbar spine revealed significant scoliotic deformity as well as lateral subluxation and spondylolisthesis. The provider documented the employee had sensory abnormalities bilaterally at the L4, L5 and S1 dermatomes upon physical exam. The provider reported the employee's pain has become progressively worse and states that the employee requires surgical interventions consisting of an anterior posterior fusion to address significant degenerative changes and levoscoliosis. The provider recommended an MRI and CT scan of the lumbar spine for surgical planning. A request was submitted for an MRI of the lumbar spine.

The ACOEM Guideline indicates, "When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." The documentation submitted and reviewed lacks

evidence that physiologic evidence of nerve dysfunction has been obtained. Further, there are no records provided for review to clarify if or when the employee last underwent an MRI of the lumbar spine or the findings. Thus, the ACOEM criteria for additional imaging have not been met. The request for an MRI of the lumbar spine **is not medically necessary and appropriate.**

2) Regarding the request for a CT scan 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 Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12, pages 303-305), which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Low Back Chapter, CT section, which is a medical treatment guideline that is not part of the MTUS. 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 11/9/1995 and presents with lumbar spine pain. The employee has been diagnosed with displacement cervical disc without myelopathy and displacement thoracic disc without myelopathy. An initial comprehensive spine consultation dated 6/3/2013 noted daily pain and discomfort to the low back rated at 6/10 to 8/10. The provider documented x-rays of the lumbar spine revealed significant scoliotic deformity as well as lateral subluxation and spondylolisthesis. The provider documented the employee had sensory abnormalities bilaterally at the L4, L5 and S1 dermatomes upon physical exam. The provider reported the employee's pain has become progressively worse and states that the employee requires surgical interventions consisting of an anterior posterior fusion to address significant degenerative changes and levoscoliosis. The provider recommended an MRI and CT scan of the lumbar spine for surgical planning. . A request was submitted for CT lumbar spine.

The documentation submitted and reviewed lacks evidence that physiologic evidence of nerve dysfunction has been obtained. Further, there are no records provided for review to clarify if or when the employee last underwent a CT of the lumbar spine or the findings. Thus, the ACOEM criteria for further imaging have not been met. The request for CT lumbar 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

/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.