

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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**Notice of Independent Medical Review Determination.
Case Number CM13-0000179**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the magnetic resonance imaging (MRI) of upper extremity requested **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on April 15, 2013 disputing the Utilization Review Denial dated April 3, 2013. A Notice of Assignment and Request for Information was provided to the above parties on April 16, 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 magnetic resonance imaging (MRI) of upper extremity requested is medically necessary and appropriate.

Medical Qualifications of the Professional 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 Radiology 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 professional 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 4, 2013

“This 29-year-old male reported a work related injury on 2/11/13 as a result of pulling down a guitar and strained his right shoulder. Subsequently, the patient had been treated for the diagnoses of right shoulder strain/sprain. The clinical note, date 3/25/13, reported that the patient had completed a course of physical therapy interventions. The provider documented that the patient presented with slight impairments in active range of motion (ROM) and strength of the right shoulder. The provider documented that the patient continued with pain complaints when performing work related activities. The clinical note date 3/26/13, reported that the patient was seen for follow-up under the care of Dr. Doshi. The provider documented that the patient returned with pain to his right shoulder, which was reported as intermittent. The patient described pain as sharp and burning. Grip strength was noted to be 20, 36, 30 to the right and 50, 40, 50 to the left hand. The provider documented that the patient’s shoulder X-rays were normal and requested an MRI of the patient’s right upper extremity. Additionally, the provider documented a request for additional physical therapy, as per the patient.”

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
- Utilization Review Letter by [REDACTED] (dated April 4, 2013)
- External Medical Review letter by [REDACTED] (dated April 3, 2013)

1) Regarding the Request for magnetic resonance imaging (MRI) of upper extremity:**Medical Treatment Guideline(s) Relied Upon by the Professional Reviewer to Make His/Her Decision:**

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Addition. The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee has persistent posterior deltoid and trapezius pain with normal range of motion. There is a possibility of a rotator cuff disease as opposed to the diagnosis of brachial neuritis. The employee continues to have pain which could be related to a rotator cuff injury. This has persisted over a 6-week time period despite non-steroidal anti-inflammatory drugs and physical therapy. X-rays have been negative. The MRI requested 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.