
Notice of Independent Medical Review Determination

Dated: 9/30/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/9/2013
Date of Injury: 3/19/2013
IMR Application Received: 7/16/2013
MAXIMUS Case Number: CM13-0001681

- 1) MAXIMUS Federal Services, Inc. has determined the request for computerized range of motion testing **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for psychiatric sessions **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for physical therapy for the lumbar spine, shoulders, wrists, two (2) times a week for six (6) weeks **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for MRI of the lumbar spine **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for MRI of the cervical spine **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for MRI 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 7/16/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 computerized range of motion testing **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for psychiatric sessions **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for physical therapy for the lumbar spine, shoulders, wrists, two (2) times a week for six (6) weeks **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for MRI of the lumbar spine **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for MRI of the cervical spine **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for MRI 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 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 July 9, 2013:

“Patient is a 59 year old female who has sustained a work- related injury to the neck, back, right shoulder, knees and right wrist on 03/19/12. Mechanism of injury is due to sexual assault where she was grabbed by her right wrist, she fought and pulled away. Reported Diagnosis is PTSD, chronic sprain/strain of cervicothoracic spine, tendonitis and impingement right shoulder. chronic sprain/strain thoracolumbar spine, osteoarthritis left L4-L5 facets, disc protrusions at L4-L5 and L5-S1. Treatment to date includes medication (not documented). Diagnostic studies: Xrays, MRI right knee (reports are not available for review), MRI L/spine 7/24/12 revealed 3.1 mm posterior disc protrusions at L4-L5 and L5-S1, Impingement of left traversing L5 root,

osteoarthritis of left L4-5 facet, mild right L5-S1 NF narrowing. Work status: she is currently TTD.

“Medical progress report dated 6/05/13 states patient is c/o anxiety, depression and posttraumatic stress disorder, nightmares, difficulty sleeping. Physical exam reveals tenderness at C3-C5, T4-T5, T10-T11, L3- S1. She has tenderness in both shoulders R > L. ROM of shoulders flexion 170 bilaterally, abduction 170 bilaterally, int rot 60 degrees on right 80 degrees on left. There is impingement of right shoulder. She is tender in both knees, McMurray's and Aplay's tests are borderline.

“This is a request dated 6/05/13 for computerized ROM study, supportive psychiatric therapy, PT 2 x 6 for back, right shoulder, knees, MRI neck, back, shoulders, both knees and right wrist.”

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 7/16/13)
- Utilization Review Determination from [REDACTED] (dated 7/9/13)
- Medical records from [REDACTED]
- Medical records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)
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1) Regarding the request for computerized range of motion testing:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (2010) Low Back Disorders, computerized range of motion testing, and AMA Guides to the Evaluation of Permanent Impairment, (5th edition), pg. 400, both are Medical Treatment Guidelines (MTG), but not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated MTUS did not specifically address the issue at dispute and 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 March 19, 2012 to the neck, back, right shoulder, knees and right wrist. The medical records provided for review indicate the diagnoses of PTSD, chronic sprain/strain of cervicothoracic spine, tendonitis and impingement right shoulder, chronic sprain/strain thoracolumbar spine, osteoarthritis left L4-L5 facets, disc protrusions at L4-L5 and L5-S1. Treatments have included medication management, diagnostic studies, and psychological treatment. The request is for computerized range of motion testing.

The Official Disability Guidelines (ODG) indicate the relationship between lumbar range of motion measures and functional ability is weak or nonexistent. In this case, the medical records provided reveal that the treating physician has

performed range of motion measurements on the employee without the need of computerized range of motion testing. The request for computerized range of motion testing **is not medically necessary and appropriate.**

2) Regarding the request for psychiatric sessions:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (5th edition) (2007), Cognitive therapy for PTSD, a Medical Treatment Guideline (MTG), which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 101-102, which are a part of MTUS and relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on March 19, 2012 to the neck, back, right shoulder, knees and right wrist. The medical records provided for review indicate the diagnoses of PTSD, chronic sprain/strain of cervicothoracic spine, tendonitis and impingement right shoulder, chronic sprain/strain thoracolumbar spine, osteoarthritis left L4-L5 facets, disc protrusions at L4-L5 and L5-S1. Treatments have included medication management, diagnostic studies, and psychological treatment. The request is for psychiatric sessions.

The MTUS Chronic Pain guidelines do indicate that psychological treatment is recommended for appropriately identified patients during treatment for chronic pain, and cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. However, the medical records reviewed do not document any improvement with the previously completed psychological treatment which would meet guideline criteria for continuance. The request for psychiatric sessions **is not medically necessary and appropriate.**

3) Regarding the request for physical therapy for the lumbar spine, shoulders, wrists, two (2) times a week for six (6) weeks :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009) pg. 98-99, which is a 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 March 19, 2012 to the neck, back, right shoulder, knees and right wrist. The medical records provided for review indicate the diagnoses of PTSD, chronic sprain/strain of cervicothoracic spine, tendonitis and impingement right shoulder, chronic sprain/strain

thoracolumbar spine, osteoarthritis left L4-L5 facets, disc protrusions at L4-L5 and L5-S1. Treatments have included medication management, diagnostic studies, and psychological treatment. The request is for physical therapy for the lumbar spine, shoulders, wrists, two (2) times and a week for six (6) weeks.

The MTUS Chronic Pain guidelines recommend a fading of treatment frequency to a home exercise program. The medical records provided for review lack documentation of the effectiveness of the previously completed physical therapy treatment and chiropractic manipulations which would meet guideline criteria for continuance. The request for physical therapy for the lumbar spine, shoulders, wrists, two (2) times and a week for six (6) weeks **is not medically necessary and appropriate.**

4) Regarding the request for 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 Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 303-304, which is part of the Medical Treatment Utilization Schedule (MTUS) as well as the Official Disability Guidelines (ODG), (5th Edition (2007), Low Back, a Medical Treatment Guideline (MTG), which is not part of MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 303-304 which is part of the MTUS and relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on March 19, 2012 to the neck, back, right shoulder, knees and right wrist. The medical records provided for review indicate the diagnoses of PTSD, chronic sprain/strain of cervicothoracic spine, tendonitis and impingement right shoulder, chronic sprain/strain thoracolumbar spine, osteoarthritis left L4-L5 facets, disc protrusions at L4-L5 and L5-S1. Treatments have included medication management, diagnostic studies, and psychological treatment. The request is for MRI of the lumbar spine.

The MTUS ACOEM guidelines only support a repeat MRI if there are progressive neurological deficits or a new injury. The medical records provided for review indicate that the employee had a previous MRI, and the records lacked documentation of progressive neurological deficits or a new radiculopathy. The request for MRI of the lumbar spine **is not medically necessary and appropriate.**

5) Regarding the request for MRI of the cervical 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), 2nd Edition, 2004, Chapter

12), Low Back, pg 303-304, which is part of the Medical Treatment Utilization Schedule (MTUS) as well as the Official Disability Guidelines (ODG), (5th Edition (2007), Low Back, a Medical Treatment Guideline (MTG), which is not part of MTUS . The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), pg. 177-179, which is part of the MTUS and relevant and appropriate for the employee's clinical condition.

Rationale for the Decision:

The employee sustained a work-related injury on March 19, 2012 to the neck, back, right shoulder, knees and right wrist. The medical records provided for review indicate the diagnoses of PTSD, chronic sprain/strain of cervicothoracic spine, tendonitis and impingement right shoulder, chronic sprain/strain thoracolumbar spine, osteoarthritis left L4-L5 facets, disc protrusions at L4-L5 and L5-S1. Treatments have included medication management, diagnostic studies, and psychological treatment. The request is for MRI of the cervical spine.

The MTUS ACOEM guidelines only support a repeat MRI if there are progressive neurological deficits or a new injury. The medical records provided for review indicate that the employee had a previous MRI, and the records lacked documentation of progressive neurological deficits or a new radiculopathy. The request for MRI of the cervical spine **is not medically necessary and appropriate.**

6) Regarding the request for MRI of the thoracic 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), 2nd Edition, 2004, Chapter 12), Low Back, pg 303-304, which is part of the Medical Treatment Utilization Schedule (MTUS) as well as the Official Disability Guidelines (ODG), (5th Edition (2007), Low Back, a Medical Treatment Guideline (MTG), which is not part of MTUS . The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 303-304 which is part of the MTUS and relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on March 19, 2012 to the neck, back, right shoulder, knees and right wrist. The medical records provided for review indicate the diagnoses of PTSD, chronic sprain/strain of cervicothoracic spine, tendonitis and impingement right shoulder, chronic sprain/strain thoracolumbar spine, osteoarthritis left L4-L5 facets, disc protrusions at L4-L5 and L5-S1. Treatments have included medication management, diagnostic studies, and psychological treatment. The request is for MRI of the thoracic spine.

The MTUS ACOEM guidelines only support a repeat MRI if there were progressive neurological deficits or a new injury. The medical records provided for review indicate that the employee had a previous MRI, and the records lacked documentation of progressive neurological deficits or a new radiculopathy. The request for MRI of the thoracic 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

/hs

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.