
Notice of Independent Medical Review Determination

Dated: 12/11/2013

[REDACTED]

[REDACTED]

| | |
|---------------------------|--------------|
| Employee: | [REDACTED] |
| Claim Number: | [REDACTED] |
| Date of UR Decision: | 7/18/2013 |
| Date of Injury: | 3/31/2011 |
| IMR Application Received: | 7/19/2013 |
| MAXIMUS Case Number: | CM13-0002197 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for an **MRI 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 7/19/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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.**

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 has a subspecialty in Internal Medicine, Physical Medicine Rehab, Orthopedic & Toxicology 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 18, 2013:

This is a "48 y/o female who presented for medical f/u with multiple complaints in the neck, low back, and bilateral hand pain. Notes numbness and tingling from mid thigh down legs, same sensation in finger tips, along with increased lower back pain. Quality of sleep is poor and activity level has decreased. Notes increased low back pain and radiates down legs. Pain meds are not controlling pain very well, requesting increase and EE smokes 1 PPD. Current meds: Oxycodone, Oxycontin, Soma, and Xanax. Surgery: Cervical anterior cervical fusion C3-C7 and posterior cervical fusion at C3-T1 level 03-22-2013 Exam: 139, C Spine: surgical scar. Restricted ROM: flexion 20, bilateral lateral rotation 20, left lateral rotation 50, right 70. Extension normal. Tenderness paravertebral and at the rhomboid and trapezius. Spurlings positive for cervical pain, negative for radiculopathy. Lumbar spine: restricted ROM Flexion 20, extension 10, bilateral rotation, positive facet loading, and straight leg rising. Light touch sensation decreased over L4 and L5".

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 7/19/13)
- Utilization Review Determination from Coventry (dated 7/18/13)
- Employee Medical Records from the Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

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), 2nd Edition, (2004) Chapter 12 – Lower Back Complaints, which is part of the MTUS. And the Official Disability Guidelines (ODG) – Treatment for Workers’ Compensation, Online Edition Chapter: Low Back – Lumbar & Thoracic, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), which is part of the MTUS, and the Official Disability Guidelines (ODG), Treatment for Workers’ Compensation, Online Edition Low Back Chapter, Lumbar & Thoracic, which is not part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM Guidelines indicate that repeat imaging can occur only if there is significant change in symptoms on exam findings including significant pathology such as tumor, infection or recurrent herniation. According to the medical records provided for review, this case had no red flags or prior surgery. **The request for an MRI of the 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;

Paul Manchester, MD, MPH
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.