

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 10/29/2013

[REDACTED]

[REDACTED]

| | |
|---------------------------|--------------|
| Employee: | [REDACTED] |
| Claim Number: | [REDACTED] |
| Date of UR Decision: | 7/17/2013 |
| Date of Injury: | 4/11/2008 |
| IMR Application Received: | 7/25/2013 |
| MAXIMUS Case Number: | CM13-0003244 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for one (1) arthrogram of the right hip **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 one (1) arthrogram of the right hip **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 17, 2013

"The patient is a 25-year-old female who sustained a low back injury on 04/11/2008 when she fell down landing on her buttocks, low back and tail bone. The patient's diagnoses are lumbar disc herniation without myelopathy, lumbar neuritis/radiculitis and right hip derangement. A request was made for MR arthrogram of the right hip. The patient's history is significant for coccygectomy and osteotomy dated 8/14/09. Other treatments to date include physical therapy, acupuncture, chiropractic treatments, and cortisone injections into her coccyx. MRI of the lumbar spine dated 3/9/12 showed L4-5 diffuse disc protrusion with effacement of the thecal sac, and hypertrophy of facet joints. As per 6/28/13 visit note, the patient complained of low back pain. This was associated with weakness and a sensation of giving way. The patient also complained of bilateral buttock pain. Current medication regimen includes Lexapro, Valium, tramadol, Norco, Soma, and Allegra. Pertinent examination findings include a normal neurologic evaluation and unremarkable evaluation of the right thigh/hip. The most recent report submitted did not show objective evidence suggestive of soft tissue abnormalities, fractures, or ligamentous tears to warrant the requested imaging study. Also, there was no documented evidence of a previous plain radiograph performed as part of this the patient's ongoing evaluation. The medical necessity of the request is not established. "

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 Determination
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request one (1) arthrogram of the right hip:

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) Online Edition Chapter: Hip & Pelvis, which is a Medical Treatment Guidelines (MTG) but not a part of MTUS. The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the ODG (current version), Hip & Pelvis Chapter, Arthrography, a MTG not a part of the MTUS.

Rationale for the Decision:

The employee sustained a low back injury on 4/11/2008. The submitted and reviewed medical records indicate the employee's diagnoses include lumbar disc herniation without myelopathy, lumbar neuritis/radiculitis and right hip derangement. The records note that a request for MR arthrogram was made on 7/15/13 but no progress report dated 7/15/13 was submitted for review. There were no records provided by the treating provider offering a rationale for the requested study. The records indicate the employee has a history of severe right hip pain radiating down the leg with decreased range of motion and cracking. An MRI of the right hip dated 3/15/13 was noted to be unremarkable. There were no soft tissue masses seen, no labral tear, and no findings suggestive of ligamentous or muscular injury.

The Official Disability guidelines recommend hip arthrography for suspected labral tears. Arthrography gains additional sensitivity when combined with a CT scan in the evaluation of internal derangement, loose bodies, and articular cartilage surface lesions. The reviewed records do not indicate the necessity for the requested MR arthrogram of the right hip. The request for MR arthrogram of the right hip **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

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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.