MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 10/16/2013

[redacted]

[redacted]

Employee:	[redacted]
Claim Number:	
Date of UR Decision:	7/5/2013
Date of Injury:	3/23/1994
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003267

1) MAXIMUS Federal Services, Inc. has determined the request for cervical MRI **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for right shoulder MRI **is medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for three-way x-ray of the right shoulder **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 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 cervical MRI **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for right shoulder MRI **is medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for right shoulder three way x-ray **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 Preventative Medicine and Occupational Medicine, 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 5, 2013:

"[redacted] is a 63-year-old worker involved in a 03/23/94 industrial-related incident. In the submitted 06/27/13 provider's evaluation, it notes the patient is complaining of right shoulder pain primarily radiating into the right neck and down the right arm. She has complaints of pain in the right thumb and also the wrist. This is due to repetitive stress caused by working on a computer. The patient was treating with another practitioner but has not been seen by that practitioner in a year and received two previous cortisone injections with some temporary relief. The patient presented on 06/27/13 more than 19 years post-onset complaining of neck pain to the head, right side and normal cervical lordosis, normal posture, compression test negative, no upper extremity atrophy trapezius and right paracervical tenderness, normal cervical range-of-motion and strength, normal sensory testing. The shoulder inspection was normal,· atrophy non-tenderness, some diffuse deltoid tenderness, anterior bicipital groove tenderness on the right but not on the left, radial scar to the left shoulder, shoulder flexion 160 degrees, abduction 160 degrees, external rotation 75 degrees, internal rotation 85 degrees, extension 50 degrees, adduction 50 degrees, Hawkins, and equivocal Neer's. The request is for cervical MRI, right shoulder MRI, and right shoulder three-view x-ray, pain in the right thumb and wrist. The examination showed cervical spine normal"

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 dated 7/25/2013
- Utilization Review Determination from Claims Administrator [redacted] dated 7/05/2013
- Employee medical records from [redacted]
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for cervical MRI:**

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) Current Version, Neck Chapter, MRI, 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 Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-8, which is part of the MTUS.

Rationale for the Decision:
The employee sustained a work-related injury on 3/23/1994 to the neck and shoulder. The medical records provided for review indicate a diagnosis of right shoulder impingement syndrome versus partial or full-thickness tear and possible cervical radiculopathy. The medical report of 6/27/2013 documents that the employee has normal cervical range-of-motion, normal muscle strength, normal arm sensory, abnormal right shoulder range-of-motion with flexion to 160 degrees, and persistent neck and shoulder pain radiating down the right arm. The medical records provided for review indicate treatments have included oral analgesic medications, two prior shoulder corticosteroid injections, and prior left shoulder arthroscopy. The request is for cervical MRI.

The MTUS/ACOEM Guidelines recommend MRI or CT to validate the diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The medical records provided for review indicate that the employee's symptoms are coming from the shoulder as opposed to the neck, and the normal arm strength does not indicate a cervical pathology or cervical nerve root compromise. The request for cervical MRI **is not medically necessary and appropriate.**

2) **Regarding the request for right shoulder MRI:**

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), Current Version, Shoulder Section, MRI, 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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), Table 9-6, which is part of the MTUS.

Rationale for the Decision:
The employee sustained a work-related injury on 3/23/1994 to the neck and shoulder. The medical records provided for review indicate a diagnosis of right shoulder impingement syndrome versus partial or full-thickness tear and possible cervical radiculopathy. The medical report of 6/27/2013 documents that the employee has normal cervical range-of-motion, normal muscle strength, normal arm sensory, abnormal right shoulder range-of-motion with flexion to 160 degrees, and persistent neck and shoulder pain radiating down the right arm. The medical records provided for review indicate treatments have included oral analgesic medications, two prior shoulder corticosteroid injections, and prior left shoulder arthroscopy. The request is for right shoulder MRI.

The MTUS/ACOEM Guidelines recommend an MRI for preoperative evaluation of partial-thickness or large full-thickness rotator cuff tears. The medical records provided for review indicate that because of the chronicity of the employee's complaints, failure to progress with time, medications, and corticosteroid injections, MRI imaging is indicated. The request for right shoulder MRI **is medically necessary and appropriate.**

3) Regarding the request for three-way x-ray of the right shoulder:

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) Current Version, Shoulder Section, imaging, 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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9, pg. 207-209, which is part of the MTUS.

Rationale for the Decision:
The employee sustained a work-related injury on 3/23/1994 to the neck and shoulder. The medical records provided for review indicate a diagnosis of right shoulder impingement syndrome versus partial or full-thickness tear and possible cervical radiculopathy. The medical report of 6/27/2013 documents that the employee has normal cervical range-of-motion, normal muscle strength, normal arm sensory, abnormal right shoulder range-of-motion with flexion to 160 degrees, and persistent neck and shoulder pain radiating down the right arm. The medical records provided for review indicate treatments have included oral analgesic medications, two prior shoulder corticosteroid injections, and prior left shoulder arthroscopy. The request is for three-way x-ray of the right shoulder.

The MTUS/ACOEM Guidelines indicate that shoulder plain films are scored a 1/4 in their ability to identify and define suspected rotator cuff tears, the diagnosis set forth by the treating provider. The medical records provided for review indicate that there is a possible rotator cuff tear and MRI imaging has been deemed

medically necessary which eliminates the need for plain films. The request for three-way x-ray of the right shoulder **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.