

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/10/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/14/2013
Date of Injury:	6/30/2008
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004855

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

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/14/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 MR arthrogram 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 Neurology, 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.

### **Expert Reviewer Case Summary:**

The patient is a 47 year old woman injured 6/30/2008. She was lifting heavy boxes with subsequent back and shoulder pain. She has had L4-5 fusion, with residual pain and numbness, and findings of arachnoiditis. UR records indicate that she has had right hip pain, with pain relief with trochanteric bursa injection. Symptoms have been attributed to the trochanteric bursa . She has had 2 trochanteric bursa injections. There was pain relief for 2 months after the 1<sup>st</sup> injection. MR arthrogram was requested after the 2<sup>nd</sup> injection.

### **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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request for one MR arthrogram right hip:**

#### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Arthrography and Magnetic Resonance Imaging (MRI) sections, which are not part of the 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 Official Disability Guidelines (ODG), Hip and Pelvis section.

Rationale for the Decision:

ACOEM and Chronic Pain Medical Treatment Guidelines do not reference MR arthrography. The Official Disability Guidelines state that MR arthrography is recommended for suspected labral tears. Magnetic resonance (MR) arthrography has been investigated in every major peripheral joint of the body, and has been proven to be effective in determining the integrity of intraarticular ligamentous and fibrocartilaginous structures and in the detection or assessment of osteochondral lesions and loose bodies in selected cases. (Sahin, 2006) A combination of MR arthrography and a small field of view is more sensitive in detecting labral abnormalities than is conventional MRI with either a large or a small field of view.

The reviewed clinical notes for this employee indicate chronic back and radicular issues, status post lumbar surgery. The records indicate the treating physician feels the hip are due to the trochanteric bursa and have responded to injection. No clinical information is supplied to indicate a concern for a labral tear. MR arthrography is not supported by guidelines. **The request for one MR arthrogram 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,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> 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.