

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	2/10/2012
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005640

- 1) MAXIMUS Federal Services, Inc. has determined the request for **MRI bilateral knees, lumbar spine, and cervical spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **EMG/NCS upper and lower extremity is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/20/2013. 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 **MRI bilateral knees, lumbar spine, and cervical spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **EMG/NCS upper and lower extremity is 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.

Expert Reviewer Case Summary:

The patient has a date of injury 2/10/12. The patient's diagnoses include cervical spine strain; rule out radiculopathy, lumbar radiculopathy, and bilateral knee internal derangement. The initial evaluation report by [REDACTED], MD dated 3/19/13 noted that the patient underwent right lower lumbar surgery in 2003. The patient complained of neck pain, low back pain radiating to his left side and intermittent numbness and tingling in his legs, bilateral hip pain, and bilateral knee pain with clicking popping and locking. It was noted that the patient presented to a physician sometime in May or June of 2012. He did not like the services there and was not treated. The patient did not recall any treatment for this injury to date. A request was made for MRI of both knees and lumbar spine and cervical spine. EMG/NCS of the bilateral upper and lower extremities were also requested to assess for neuropathy versus entrapment neuropathy. No other rationale was given for the request.

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 Sedgwick
- Medical Records from Provider
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for MRI bilateral knees, lumbar spine, and cervical spine:

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 ODG, Indications for Imaging-MRI, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) Special Studies and Diagnostic Treatment Considerations, pg.177-178, Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) Special Studies, pg. 303, and the Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13), Special Studies, pg. 341-343, which are all a part of the MTUS.

Rationale for the Decision:

The employee has a date of injury 2/10/12. The employee's diagnoses include cervical spine strain; rule out radiculopathy, lumbar radiculopathy, and bilateral knee internal derangement. A review of the records indicates the initial evaluation report dated 3/19/13 noted that the employee reported that there had not been any conservative treatment for this injury. There were no medical records documenting any conservative treatments prior to the 3/19/13 evaluation. ACOEM guidelines do not support diagnostic studies without failure of conservative therapy and absence of any red flags. No rationale was documented by the treater for the requested MRIs. **The request for MRI bilateral knees, lumbar spine, and cervical spine is not medically necessary and appropriate.**

2) Regarding the request for EMG/NCS upper and lower extremity:

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 ACOEM Practice Guidelines 2nd Ed., Neck and Upper Back Complaints Chapter, pg. 178 and table 8-8, as referenced in MTUS, which is a part of the MTUS.

The Expert Reviewer based his/her decision on Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) Special Studies and Diagnostic Treatment Considerations, pg.177-178, and Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) Special Studies, pg. 303, which is a part of the MTUS.

Rationale for the Decision:

The employee has a date of injury 2/10/12. The employee's diagnoses include cervical spine strain; rule out radiculopathy, lumbar radiculopathy, and bilateral knee internal derangement. ACOEM supports the use of electrodiagnostic studies in patients with neck or arm symptoms, or both, lasting more than three or four weeks. ACOEM also supports electrodiagnostic studies for patients with low back pain lasting more than 3-4 weeks. A review of the records provided, the medical records dated 3/19/13 noted that the patient complained of neck pain, low back pain radiating to his left side and intermittent numbness and tingling in his legs. **The request for EMG/NCS upper and lower extremity is 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.