

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
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(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the range of motion testing requested **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the six (6) chiropractic visits requested **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the 3D MRI of cervical spine requested **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the 3D MRI of thoracic spine requested **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the 3D MRI of lumbar spine requested **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the pharmacological consultation requested **is not medically necessary and appropriate.**

- 7) MAXIMUS Federal Services, Inc. has determined the functional capacity evaluation requested **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the one (1) multi inferential stimulator requested **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the one (1) lumbar orthosis requested **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 4/26/2013 disputing the Utilization Review Denial dated 4/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 4/29/2013. 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 range of motion testing requested **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the six (6) chiropractic visits requested **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the 3D MRI of cervical spine requested **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the 3D MRI of thoracic spine requested **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the 3D MRI of lumbar spine requested **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the pharmacological consultation requested **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the functional capacity evaluation requested **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the one (1) multi inferential stimulator requested **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the one (1) lumbar orthosis requested **is not medically necessary and appropriate.**

Medical Qualifications of the Professional 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 Internal 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 professional 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 April 22, 2013.

██████████ is a 42 year old female correctional officer with a date of injury of 3/06/2013. The carrier has accepted Soft Tissue-Head, Facial Bones, Disc-Neck, and Disc Back as injured body parts for this industrial injury claim. She was injured when she fell backward on an uneven surface and struck her head. Diagnoses on 4/10/13 were Cervical Disc Herniation with Myelopathy, Thoracic Disc Displacement with Myelopathy, Lumbar Disc Displacement with Myelopathy, Lesion of Sciatic Nerve, Post Concussion Syndrome, tension headache, and Vertigo.

“MEDICAL RECORD SUMMARY:

-04/10/13 B. ██████████ M.D.; Subjective: Complains of head pain, cervical, thoracic and lumbar spine pain. Tinnitus and vertigo. Objective: See detailed findings. Diagnoses: Cervical Disc Herniation with Myelopathy. Thoracic Disc Displacement with Myelopathy. Lumbar Disc Displacement with Myelopathy. Lesion of Sciatic Nerve. Post Concussion Syndrome. Headache, tension. Vertigo. Plan: Conservative therapy for 6 visits. Range of motion testing. 3D MRI's of cervical, thoracic and lumbar spine. Functional capacity evaluation. Multi interferential stimulator. Lumbar orthosis.”

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 by ██████████ (dated 4/22/13)
- Employee's Medical Records by ██████████ (dated 4/10/13)
- Employee's Medical Records by ██████████ (dated 3/8/13)
- Employee's Medical Records by ██████████ (dated 3/11/13 through 4/4/13)
- Official Disability Guidelines (ODG) (updated 4/15/13) – Low Back Chapter: Flexibility Section
- Chronic Pain Medical Treatment Guidelines (2009) – Pages 46 and 98
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) – Chapter 12: Low Back Complaints (Page 299 – 308); Chapter 8: Neck and Upper Back Complaints (Pages 173 – 178); Chapter 7: Independent Medical Examinations and Consultations

1) Regarding the request for range of motion testing:

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (updated 4/15/13) - Low Back Chapter: Flexibility Section because American College of Occupational and Environmental Medicine (ACOEM) guidelines of the Medical Treatment Utilization Schedule (MTUS) do not address range of motion testing. The provider used the Chronic Pain Medical Treatment Guidelines (2009) – Pages 46 and 98 and ACOEM guidelines for conservative therapy (direct citation not provided) of the MTUS to support their request for authorization. The Professional Reviewer found the American College of Occupational and Environmental Medicine (ACOEM) guidelines of the Medical

Treatment Utilization Schedule (MTUS) did not address range of motion testing and agreed that the referenced ODG section used by the Claims Administrator was relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed "concussive syndrome". Work restrictions and medication were prescribed. The employee developed headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

Upon review of the clinical records provided the Professional Reviewer agreed with the diagnosis as stated on 4/10/13. In the providers Initial Evaluation and Request for Authorization Report dated 4/10/13 range of motion testing was requested to measure the employee's overall functional improvement to conservative therapies. ACOEM guidelines do not address the issue of range of motion testing. ODG's do not support range of motion testing stating, "the relation between lumbar range of motion measures and functional ability is weak and nonexistent". Therefore, the requested range of motion testing **is not medically necessary and appropriate.**

2) Regarding the request for 6 chiropractic visits:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional 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: Low Back Complaints (Page 299), of the Medical Treatment Utilization Schedule (MTUS). The provider used the Chronic Pain Medical Treatment Guidelines (2009) – Pages 46 and 98 and ACOEM guidelines for conservative therapy (direct citation not provided) of the MTUS to support their request for authorization. The Professional Reviewer found the referenced ACOEM guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed "concussive syndrome". Work restrictions and medication were prescribed. The employee developed

headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

Upon review of the clinical records submitted for review the employee was authorized and underwent six (6) sessions of chiropractic treatment. These did not provide any improvement. ACOEM guidelines state, "If manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated." Therefore, the requested six (6) chiropractic sessions **are not medically necessary and appropriate.**

3) Regarding the request for 3D MRI of cervical spine:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional 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 8: Neck and Upper Back Complaints (Pages 177-178), of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed "concussive syndrome". Work restrictions and medication were prescribed. The employee developed headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

The ACOEM guidelines recommend imaging when there is evidence of tissue insult or neurologic dysfunction, an emergence of a red flag, failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure. Upon review of the medical records provided, the employee continues to experience cervical pain, but there is no evidence of tissue insult or any of the other criteria listed that would warrant the need for an MRI of the cervical spine. Therefore, the request for a 3D MRI of the cervical spine **is not medically necessary and appropriate.**

4) Regarding the request for 3D MRI of thoracic spine:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional 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 8: Neck and Upper Back Complaints (Pages 177-178), of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed "concussive syndrome". Work restrictions and medication were prescribed. The employee developed headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

The ACOEM guidelines recommend imaging when there is evidence of tissue insult or neurologic dysfunction, an emergence of a red flag, failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure. Upon review of the medical records provided, the employee continues to experience pain in the thoracic spine region, but there is no evidence of tissue insult or any of the other criteria listed that would warrant the need for an MRI of the thoracic spine. Therefore, the request for a 3D MRI of the thoracic spine **is not medically necessary and appropriate**.

5) Regarding the request for 3D MRI of lumbar spine:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional 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: Low Back Complaints (Page 304), of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed “concussive syndrome”. Work restrictions and medication were prescribed. The employee developed headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

The ACOEM guidelines recommend that “imaging studies should be reserved for cases in which surgery is considered or red flag diagnoses are being evaluated”. Upon review of the medical records provided, although the employee continues to experience pain in the lumbar spine region, there is no evidence of a lumbar surgical lesion or red-flag diagnosis. Therefore, the request for a 3D MRI of the lumbar spine **is not medically necessary and appropriate**.

6) Regarding the request for pharmacological consultation:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional 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 8: Neck and Upper Back Complaints (Page 173), of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed “concussive syndrome”. Work restrictions and medication were prescribed. The employee developed headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

Upon review of the clinical records provided, there is not adequate documentation or a clear rationale provided to support a pharmacological

consultation. ACOEM guidelines state, “if treatment response is inadequate (i.e., if symptoms and activity limitation continue), prescribed pharmaceuticals or physical methods can be added”. The provider is a medical doctor and capable of prescribing pharmaceuticals for pain control. Therefore, the request for a pharmacological consultation **is not medically necessary and appropriate**.

7) Regarding the request for functional capacity evaluation:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional 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 7: Independent Medical Examinations and Consultation (Page 136), of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed “concussive syndrome”. Work restrictions and medication were prescribed. The employee developed headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

The ACOEM guidelines state, “there is little scientific evidence confirming that FCEs [functional capacity evaluations] predict an individual’s actual capacity to perform in the workplace: an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual’s abilities”. An individual’s performance can be influenced by multiple non-medical issues and have a poor predictive value. Therefore, the request for a functional capacity evaluation **is not medically necessary and appropriate**.

8) Regarding the request for 1 multi inferential stimulator:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional 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: Low Back Complaints (Page 300), of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used

by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed "concussive syndrome". Work restrictions and medication were prescribed. The employee developed headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

ACOEM guidelines state there is insufficient evidence to support the clinical effectiveness of noninvasive electrical stimulation such as interferential therapy. Therefore, the request for one (1) multi inferential stimulator **is not medically necessary and appropriate**.

9) Regarding the request for 1 lumbar orthosis:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional 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: Low Back Complaints (Page 308), of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On March 8, 2013 the employee was injured during a training session at work. The employee lost footing, fell with the back of the head hitting the floor, and experienced immediate pain in the head, neck and entire back as well as ringing in the ears. X-rays performed revealed "concussive syndrome". Work restrictions and medication were prescribed. The employee developed headaches and blurred vision for which magnetic resonance imaging (MRI) was performed. The results of the MRI were reported as negative on a medical report dated 3/25/13. Work restrictions and conservative therapy visits (chiropractic treatment) were provided, from which there was no benefit. Diagnosis on 4/10/13 was cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, post concussion syndrome, tension headache and vertigo.

ACOEM guidelines do not recommend the use of a corset (lumbar orthosis) for treatment of lumbar pain. Therefore, the request for one (1) lumbar orthosis **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.