

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
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Notice of Independent Medical Review Determination

Dated: 8/27/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 6/18/2013
Date of Injury: 3/27/2013
IMR Application Received: 6/21/2013
MAXIMUS Case Number: CM13-0000802

- 1) MAXIMUS Federal Services, Inc. has determined the request for EMG/NCV Left Lower Extremity **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for EMG/NCV Right Lower Extremity **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for MRI Lumbar Spine **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/21/2013 disputing the Utilization Review Denial dated 6/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/24/2013. 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 EMG/NCV Left Lower Extremity **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for EMG/NCV Right Lower Extremity **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for MRI Lumbar Spine **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 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 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 June 18, 2013

“Mechanism of Injury: Bent over to pick up a carpel felt a pulling pain to the low back. X-rays to the low back completed: As per provided clinical information: 0512912013: There is intermittent moderate to severe low back< pain. The pain is increased by prolonged sitting, standing, walking. The pain is a 7/10.

“Physical Examination: Lumbar: Forward Flexion: 10 Inches from the ground. The patient walks with a limp. The patient is unable to walk on the toes and heels without local motor deficit. Sensation as assessed by pinwheel is decreased at L5-S1 to the right side. Straight Leg Raise: Supine: Positive at 90 degrees, Sitting: Positive at 90 degrees. Medications | Medication History: Cyclobenzaprine. Date of injury: 0312712013
Diagnoses 721.3 LUMBOSACRAL SPONDYLOSIS.”

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 6/21/2013
- Utilization Review Determination(s) provided by [REDACTED] dated 6/18/2013

- Medical Records from 4/01/2013 through 6/12/2013
- Official Disability Guidelines, Low Back Section, EMG's
- Official Disability Guidelines, Low Back Section, NCV
- Official Disability Guidelines, Low Back Section, MRI
- ACOEM Guidelines, 2004, 2nd Edition, Chapter 12, Low Back Complaints, pages 303 & 304
- ACOEM Guidelines, 2004, 2nd Edition, Chapter 13, Knee Complaints, page 343

1) Regarding the request for EMG/NCV Left Lower Extremity:

Medical Treatment Guideline(s) 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) Guidelines, 2004, 2nd Edition, Chapter 12, Low Back Complaints, page 303-304, and Table 12-8, page 308, of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines (ODG), Current Version, Low Back Section, EMG/NCV, a Medical Treatment Guideline (MTG) not in the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On 3/27/13, the employee injured the low back. Initial diagnosis was low back sprain. Treatment included X-rays taken of the lower back, analgesics, and one physical therapy session. An orthopedic evaluation dated 5/29/13 revealed the employee continued to experience intermittent moderate to severe low back pain. A request was made for an EMG/NCV of the left lower extremities and an MRI of the lumbar spine.

ACOEM Guidelines, 2004, 2nd Edition, Low Back Complaints do not address NCVs in patients with back pain but does indicate that EMGs are recommended if no improvement after one month. The employee has only undertaken one session of physical therapy, which was noted to be of no benefit, and does not meet the criteria for one month of conservative care. The requested EMG/NCV for the Left Lower Extremity is not medically necessary and appropriate.

2) Regarding the request for EMG/NCV Right Lower Extremity:

Medical Treatment Guideline(s) 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) Guidelines, 2004, 2nd Edition, Chapter 12, Low Back Complaints, page 303-304, and Table 12-8, page 308, of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines (ODG), Current Version, Low Back Section, EMG/NCV, a Medical Treatment Guideline (MTG) not in the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer

found the section of the MTUS guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On 3/27/13, the employee injured the low back. Initial diagnosis was low back sprain. Treatment included X-rays taken of the lower back, analgesia and one physical therapy session. An orthopedic evaluation dated 5/29/13 revealed the employee continued to experience intermittent moderate to severe low back pain. A request was made for an EMG/NCV of the right lower extremities and an MRI of the lumbar spine.

ACOEM Guidelines, 2004, 2nd Edition, Low Back Complaints do not address NCVs in patients with back pain but does indicate that EMGs are recommended if no improvement after one month. The employee has only undertaken one session of physical therapy, which was noted to be of no benefit, and does not meet the criteria for one month of conservative care. The requested EMG/NCV for the Right Lower Extremity is not medically necessary and appropriate.

3) Regarding the request for MRI Lumbar Spine:

Medical Treatment Guideline(s) 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) 2004, 2nd Edition, Chapter 12, Low Back Complaints, MRI, pages 303, 304, and 343, of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On 3/27/13, the employee injured the low back. Initial diagnosis was low back sprain. Treatment included X-rays taken of the lower back, analgesia and one physical therapy session. An orthopedic evaluation dated 5/29/13 revealed the employee continued to experience intermittent moderate to severe low back pain. A request was made for an MRI of the Lumbar Spine.

ACOEM guidelines, 2004, 2nd Edition, Low Back Complaints, MRI, pages 303,304, and 343, of the MTUS does not recommend an MRI for a lumbar sprain or without red flag warnings. The submitted and reviewed documents do not identify any red flag signs to indicate a diagnosis other than lumbar sprain. The requested MRI for the Lumbar Spine 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.