

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/8/2013
Date of Injury: 12/31/2010
IMR Application Received: 8/13/2013
MAXIMUS Case Number: CM13-0010634

- 1) MAXIMUS Federal Services, Inc. has determined the request for **MRI Lumbar Spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **EMG/NCV (B) LE is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Physical therapy 2 times 6 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 8/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/30/2013. 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 **MRI Lumbar Spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **EMG/NCV (B) LE is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Physical therapy 2 times 6 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 Orthopedic Surgery 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 claimant is a 37-year-old female who was injured in a work related accident on December 31, 2010 sustaining injury to her low back and lower extremities.

Recent assessment of July 12, 2013 showed a diagnosis of low back pain with radiating radicular right leg pain to the heel. Physical examination findings on that date demonstrated diminished sensation to the right L5 and S1 dermatomal distribution with a positive straight leg raise and radiographs demonstrating loss of disc height and foraminal stenosis. Recommendations at that time were for diagnostic workup to include an MRI scan of the lumbar spine, electrodiagnostic studies to the lower extremities as well as a trial of physical therapy twice weekly for six weeks for further therapeutic care.

On August 8, 2013, a Utilization Review denied the request for lumbar MRI as well as electrodiagnostic testing citing prior documentation of supported radicular findings on previous electrodiagnostic studies showing a right L5 radiculopathy. Based on the claimant's neurologic findings, there was no indication for updated MRI scan or electrodiagnostic testing based on the above.

Review also modified request for physical therapy to approve six sessions for core strengthening and reconditioning.

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:



1) Regarding the request for MRI Lumbar 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 Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pgs. 303-304, which is a part of MTUS, and the Official Disability Guidelines, online treatment guidelines, which is not a part of MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pgs. 287 and 303, which is a part of MTUS, and the Official Disability Guidelines, Low Back procedures, which is not a part of MTUS.

Rationale for the Decision:

The MTUS/ACOEM Guidelines indicate repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Based on MTUS/ACOEM guidelines and supported by the Official Disability Guidelines criteria, repeat imaging would not be supported in this case. The medical records provided for review indicate the employee's recent physical examination findings were consistent with prior findings from electrodiagnostic testing. There is no indication of progressive neurologic dysfunction or change in symptomatology. **The request for MRI Lumbar Spine is not medically necessary and appropriate.**

2) Regarding the request for EMG/NCV (B) LE:

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 Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) Table 12-8, which is a part of MTUS, and the Official Disability Guidelines Sections - On Line Treatment Guidelines, which is not a part of MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 303, which is a part of MTUS.

Rationale for the Decision:

The MTUS/ACOEM Guidelines indicate Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Based on the guidelines, repeat electrodiagnostic studies to the lower extremities also would not be supported as it is documented that previous electrodiagnostic studies show radicular pattern at the L5 level consistent with the employee's current physical examination findings. Lack of change or progression of symptomatology as well as lack of physical exam findings would fail to necessitate repeat testing. **The request for EMG/NCV bilateral lower extremities is not medically necessary and appropriate.**

3) Regarding the request for Physical therapy 2 times 6 :

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 Chronic Pain Medical Treatment Guidelines, Section – Physical Medicine Guidelines, which is a part of MTUS, and the Official Disability Guidelines, Sections - On Line Treatment Guidelines for chronic pain, and Physical Therapy Guidelines, which are not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section – Physical Medicine Guidelines, pgs. 98-99, which is a part of MTUS.

Rationale for the Decision:

The MTUS Guidelines indicate passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines recommend, allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. For the diagnoses of Neuralgia, neuritis, and radiculitis: 8-10 visits over 4 weeks. The medical records provided for review indicate the employee had been authorized for six sessions of therapy in a modified fashion on August 6, 2013 review. The request for twelve additional sessions of therapy would exceed guidelines criteria for formal physical therapy sessions in the chronic setting. **The request for physical therapy 2 times 6 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, 18th Floor
Oakland, CA 94612

/hs

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.