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**Notice of Independent Medical Review Determination**

Dated: 12/16/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/4/2013  
Date of Injury: 5/11/2011  
IMR Application Received: 8/15/2013  
MAXIMUS Case Number: CM13-0011630

- 1) MAXIMUS Federal Services, Inc. has determined the request for **MRI of the lumbar spine w/gadolinium is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **EMG of the left lower extremity is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **NCV of the left lower extremity is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **home interferential unit is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #120 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **moist thermophore heat pad is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 8/4/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/23/2013. 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 of the lumbar spine w/gadolinium** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **EMG of the left lower extremity** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **NCV of the left lower extremity** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **home interferential unit** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #120** is not **medically necessary and appropriate**.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **moist thermophore heat pad** 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 Internal Medicine and Cardiology, and is licensed to practice in Texas. 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 58-year-old male who reported an injury on 05/11/2011 after being tackled by a homeless person, causing the patient to land on his back and buttocks. The patient underwent lumbar spinal surgery in 10/2011. Postoperatively he received physical therapy and medications. The patient has ongoing complaints of cervical spine pain and lumbar pain. Physical findings of the cervical spine included tenderness to palpation along the cervical paravertebral musculature and suboccipital triangle. A Spurling's maneuver elicited increased neck pain; however, did not indicate a radicular component. Physical findings of the lumbar spine included tenderness to palpation over the paravertebral musculature, a positive straight leg raising test bilaterally, disturbed sensation in the L5 and S1 nerve root distribution, and restricted range of motion secondary to pain. The patient's diagnoses included status post lumbar spinal surgery, cervical/trapezial sprain/strain, history of stress and depression secondary to orthopedic

complaints. The patient's treatment plan included chiropractic care, medication management, and participation in home exercise program.

### **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:
  - Claims Administrator
  - Employee/Employee Representative
  - Provider

### **1) Regarding the request for MRI of the lumbar spine w/gadolinium :**

#### The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Low Back Complaints, Chapter 12, pg. 303, which is part of the MTUS, and also on the Official Disability Guidelines (ODG), Low back Chapter, Lumbar & Thoracic (Acute & Chronic), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Low Back Complaints, Chapter 12, pgs. 303-305, which is part of the MTUS, and also on the Official Disability Guidelines (ODG), Low back Chapter, MRI, which is not part of the MTUS.

#### Rationale for the Decision:

The employee does have back pain with radicular symptoms. ACOEM Guidelines indicate that neurological symptoms would warrant imaging studies. However, the clinical documentation submitted for review does indicate that the employee has previously received an MRI. Official Disability Guidelines do not recommend repeat imaging unless there is evidence of a change in pathology or progressive neurological deficits. The clinical documentation submitted for review does not provide any evidence of progressive neurological deficits or any indication of a change in pathology. **The request for MRI of the lumbar spine w/gadolinium is not medically necessary and appropriate.**

### **2) Regarding the request for EMG of the left lower extremity :**

#### The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Low

Back Complaints, Chapter12, EMGs (electromyography), pg. 303, which is part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Low Back Complaints, Chapter12, pgs. 303-305, which is part of the MTUS.

Rationale for the Decision:

The employee has ongoing low back complaints with radicular symptoms. ACOEM Guidelines do not support the use of electrodiagnostic studies when the presence of radiculopathy is clearly evidenced. The employee does have a positive straight leg raising test bilaterally with disturbed sensation in the L5-S1 dermatomes. As radicular symptoms are clearly identified, an EMG study would not be supported. **The request for EMG of the left lower extremity is not medically necessary and appropriate.**

**3) Regarding the request for NCV of the left lower extremity :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) Low Back Chapter, NCV, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG) Low Back Chapter, NCV, which is not part of the MTUS.

Rationale for the Decision:

The employee does have ongoing chronic back pain with radicular symptoms into the left lower extremity. Official Disability Guidelines do not support the use of NCVs if when radicular findings related to low back pain are clearly evident. The employee does have a positive straight leg raising test, with disturbed sensation in the L5-S1 dermatomes. As radicular symptoms are clearly evident, the use of an NCV as a diagnostic tool would not be supported by guideline recommendations. **The request for NCV of the left lower extremity is not medically necessary and appropriate.**

**4) Regarding the request for home interferential unit :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS), pgs. 119-120, which are part of the MTUS.

Rationale for the Decision:

The employee does have chronic, ongoing low back complaints with radicular symptoms. Chronic Pain Medical Treatment Guidelines recommends the use of an interferential unit as an adjunct therapy to physical rehabilitation components, when the patient is unresponsive or intolerant of medications and conservative therapies. The clinical documentation submitted for review does provide evidence that the employee is participating in a home exercise program and has continued pain with medication usage. However, the use of this type of therapy should be based on a 1-month trial to establish the efficacy of this treatment modality. The clinical documentation submitted for review does not provide evidence that the employee has had a 1-month trial. **The request for home interferential unit is not medically necessary and appropriate.**

**5) Regarding the request for Norco 10/325mg #120 :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Hydrocodone/APAP, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, On-going Management, pg. 78, which is part of the MTUS.

Rationale for the Decision:

The employee has ongoing chronic low back pain with radicular symptoms. Chronic Pain Medical Treatment Guidelines recommends the ongoing use of opioids for chronic pain management when there is evidence of increased functional capabilities, symptom relief, assessment of side effects, and evidence of compliance to a prescribed medication schedule. The clinical documentation submitted for review does not provide evidence of any functional benefit as it is related to this medication. Additionally, there is no indication that the employee is being monitored for compliance to the prescribed medication schedule. **The request for Norco 10/325mg #120 is not medically necessary and appropriate.**

**6) Regarding the request for moist thermophore heat pad :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Low Back Complaints Chapter 12, Cold/heat packs, pg. 162, which is part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Low Back Complaints, Chapter 12, pg. 287-289, which is part of the MTUS.

Rationale for the Decision:

The employee has ongoing chronic low back complaints with radicular symptoms. ACOEM Guidelines recommends the use of heat to alleviate pain and allow for increased functional capabilities. As the employee has been non-responsive to other treatment modalities, the use of heat therapy to provide pain relief and allow for the employee to participate in a home exercise program would be medically appropriate. **The request for moist thermophore heat pad 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, 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.