
Notice of Independent Medical Review Determination

Dated: 11/25/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	8/31/2002
IMR Application Received:	7/16/2013
MAXIMUS Case Number:	CM13-0001623

- 1) MAXIMUS Federal Services, Inc. has determined the request for an **MRI of the lumbar spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **pain management consultation is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Ultram ER 150mg #30 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/18/2013. 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 an **MRI of the lumbar spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **pain management consultation is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Ultram ER 150mg #30 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 Physical Medicine and Rehabilitation, 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013

“The patient is a 63 year old male with a date of injury of 8/31/2002”

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 7/16/2013)
- Utilization Review from [REDACTED] (dated 7/9/2013)
- Medical Records from [REDACTED] (dated 4/12/13-5/24/13)
- Medical Records from [REDACTED] Ph.D. (dated 5/20/13-6/20/13)

1) Regarding the request for an MRI of the lumbar spine:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based guidelines for its decision.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004), Low Back Complaints, Chapter 12, pg. 303, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on August 31, 2002 to the lower back. The medical records provided for review indicate a diagnosis of lower back sprain/strain with inflammation of the spinal nerve roots in the legs. The medical report of May 23, 2013 indicated tenderness to touch, with slight spasm. Range-of-motion of the lower back measured 37 degrees of flexion, 70 degrees of extension, right side bending was 11 degrees, and left side bending was 13 degrees. The employee complained of low back pain with radiation into both legs with numbness and tingling. Treatments have included acupuncture, and muscle relaxers. The request is for an MRI of the lumbar spine.

ACOEM guidelines indicate physiological evidence may be in the form of definitive neurological findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. , Clear findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging studies if symptoms persist. The medical records provided for review does not indicate when the employee last underwent imaging studies of the lumbar spine. **The request for an MRI of the lumbar spine is not medically necessary and appropriate.**

2) Regarding the request for a pain management consultation:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not base its decision on any evidence-based guidelines.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), Chapter 7, pg. 127, which is not part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on August 31, 2002 to the lower back. The medical records provided for review indicate a diagnosis of lower back sprain/strain with inflammation of the spinal nerve roots in the legs. The medical report of May 23, 2013 indicated tenderness to touch, with slight spasm. Range-of-motion of the lower back measured 37 degrees of flexion, 70 degrees of extension, right side bending was 11 degrees, and left side bending was 13 degrees. The employee complained of low back pain with radiation into both legs with numbness and tingling. Treatments have included acupuncture, and muscle relaxer. The request is for a pain management consultation.

ACOEM Guidelines indicate consultation is utilized to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss. However, it is unclear if the employee has sought pain management treatment previously and what the employee's course of care was

recently for pain complaints. given the lack of documentation submitted evidencing the rationale and future course of treatment for this employee's chronic pain complaints, the current request is not supported. **The request for a pain management consultation is not medically necessary and appropriate.**

3) Regarding the request for Ultram ER 150mg #30:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not base its decision on any evidence-based guidelines.

The Expert Reviewer found that the Chronic Pain Medical Treatment Guidelines, pg. 93-94, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on August 31, 2002 to the lower back. The medical records provided for review indicate a diagnosis of lower back sprain/strain with inflammation of the spinal nerve roots in the legs. The medical report of May 23, 2013 indicated tenderness to touch, with slight spasm. Range-of-motion of the lower back measured 37 degrees of flexion, 70 degrees of extension, right side bending was 11 degrees, and left side bending was 13 degrees. The employee complained of low back pain with radiation into both legs with numbness and tingling. Treatments have included acupuncture, and muscle relaxer. The request is for a prescription of Ultram ER 150mg #30.

Chronic Pain Medical Treatment Guidelines indicate, "4 domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 As" (analgesia, activities of daily living, adverse side-effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." The clinical notes evidence the employee continues to present with bilateral shoulder pain as documented on the clinical note dated 05/24/2013. The clinical notes lacked evidence of the employee's current medication regimen and the reports of efficacy with the medication regimen **The request for Ultram ER 150mg #30 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

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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.