
Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/2/2013
Date of Injury: 7/12/2010
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003441

- 1) MAXIMUS Federal Services, Inc. has determined the request for surgery consultation **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for neurology consult evaluation for bilateral lower extremity EMG/NCV **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for MRI lumbar spine with contrast **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for eight sessions of massage therapy in conjunction with acupuncture, a quantity of sixteen sessions, **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for acupuncture one to two times per week for eight weeks, a quantity of sixteen sessions, **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for chest x-ray **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 surgery consultation **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for neurology consult evaluation for bilateral lower extremity EMG/NCV **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for MRI lumbar spine with contrast **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for eight sessions of massage therapy in conjunction with acupuncture, a quantity of sixteen sessions, **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for acupuncture one to two times per week for eight weeks, a quantity of sixteen sessions, **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for chest x-ray **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The 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 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 2, 2013:

“

42 year old with back injury 7/2/10. It is not documented if she is working. She is S/P Microdiscectomy right L234. Current note documents that she is scheduled for RFA. There are complaints of back pain with right lower extremity radiation. It is stated right leg is weaker than left. There is no atrophy or reflex change. Request is submitted for above

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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 (received 7/25/13)
- Utilization Review Determination from [REDACTED] (dated 7/2/13)
- Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request surgery consultation :

Medical Treatment Guideline(s) 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), 2nd Edition, (2004), surgery referral, pg. 305-306, which is part of the MTUS. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 7/02/10. The submitted medical records note right lower extremity pain and weakness and buttock pain. The employee's diagnoses include new lumbar sprain with instability, bilateral lower extremity radiculopathy, right more than left, with right-sided weakness with walking and a suggestion of low of bowel or bladder control, reactive anxiety/depression secondary to chronic pain, left fourth two fracture, L2-L3 and L4-5 microdiscectomy, right-sided, and left lid droop. Per the submitted records, prior treatment has included surgery and medications. A request has been submitted for surgery consultation.

The MTUS ACOEM guidelines note that a referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise, activity limitation due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical imaging electrophysiologic evidence of a lesion that had been shown to benefit in both the short and long term for surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. Per the submitted records, there is a lack of documentation of significant progressive neurological deficits and a lack of documentation of a neurological examination that would confirm radiculopathy. In addition, there is no indication in the records that the employee has undertaken a course of conservative therapy as physical therapy notes were not provided for review. **The request for surgery consultation is not medically necessary and appropriate.**

2) Regarding the request for neurology consult evaluation for bilateral lower extremity EMG/NCV :

Medical Treatment Guideline(s) 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), 2nd Edition, (2004), electrodiagnostic testing, table 12-8, which is part of the MTUS. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 7/02/10. The submitted medical records note right lower extremity pain and weakness and buttock pain. The employee's diagnoses include new lumbar sprain with instability, bilateral lower extremity radiculopathy, right more than left, with right-sided weakness with walking and a suggestion of low of bowel or bladder control, reactive anxiety/depression secondary to chronic pain, left fourth two fracture, L2-L3 and L4-5 microdiscectomy, right-sided, and left lid droop. Per the submitted records, prior treatment has included surgery and medications. A request has been submitted for bilateral lower extremity EMG/NCV.

The MTUS ACOEM guidelines indicate that electromyography including H-reflex tests may be useful to identify subtle focal neurological dysfunction for patients with low back symptoms lasting more than three to four weeks. Although the records indicate the employee has mild weakness in the right lower extremity, there is a lack of documentation of imaging studies to confirm this. **The request for bilateral lower extremity EMG/NCV is not medically necessary and appropriate.**

3) Regarding the request MRI lumbar spine with contrast :

Medical Treatment Guideline(s) 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), 2nd Edition, (2004), imaging for the back, pg. 303-304, which is part of the MTUS and the Official Disability Guidelines (ODG) (current version), Low back, MRI, which is not part of the MTUS. The Expert Reviewer found Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), Imaging for the back, pg. 303-304, which is part of the MTUS

Rationale for the Decision:

The employee sustained a work-related injury on 7/02/10. The submitted medical records note right lower extremity pain and weakness and buttock pain. The employee's diagnoses include new lumbar sprain with instability, bilateral lower extremity radiculopathy, right more than left, with right-sided weakness with walking and a suggestion of low of bowel or bladder control, reactive anxiety/depression secondary to chronic pain, left fourth two fracture, L2-L3 and L4-5 microdiscectomy, right-sided, and left lid droop. Per the submitted records, prior treatment has included surgery and medications. A request has been submitted for MRI lumbar spine with contrast.

The MTUS ACOEM guidelines note “relying solely on imaging studies to evaluate the source of low back and related symptoms carries significant risk for diagnostic confusion (false positive test results) because of possibility of identifying and finding it was present before symptoms began and therefore has not temporal association with the symptoms.” The records do not indicate significant progressive neurological deficits. **The request for MRI lumbar spine with contrast is not medically necessary and appropriate.**

- 4) **Regarding the request** eight sessions of massage therapy in conjunction with acupuncture, a quantity of sixteen sessions, :

Medical Treatment Guideline(s) 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), 2nd Edition, (2004), functional restoration, pg. 92, which is part of the MTUS. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 7/02/10. The submitted medical records note right lower extremity pain and weakness and buttock pain. The employee’s diagnoses include new lumbar sprain with instability, bilateral lower extremity radiculopathy, right more than left, with right-sided weakness with walking and a suggestion of low of bowel or bladder control, reactive anxiety/depression secondary to chronic pain, left fourth two fracture, L2-L3 and L4-5 microdiscectomy, right-sided, and left lid droop. Per the submitted records, prior treatment has included surgery and medications. A request has been submitted for massage therapy in conjunction with acupuncture, a quantity of sixteen sessions.

The MTUS ACOEM guidelines indicate that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS unit, percutaneous electrical nerve stimulation, and biofeedback have no proven efficacy in treating acute low back symptoms. The records submitted for review do not document significant progressive neurological deficits. **The request for massage therapy in conjunction with acupuncture, a quantity of sixteen sessions is not medically necessary and appropriate.**

- 5) **Regarding the request** acupuncture one to two times per week for eight weeks, a quantity of sixteen sessions,

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

The Claims Administrator based its decision on the Acupuncture Medical Treatment Guidelines, part of the MTUS. The Expert Reviewer based his/her decision on the Acupuncture Medical Treatment Guidelines, pg. 8-9, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 7/02/10. The submitted medical records note right lower extremity pain and weakness and buttock pain. The employee's diagnoses include new lumbar sprain with instability, bilateral lower extremity radiculopathy, right more than left, with right-sided weakness with walking and a suggestion of low of bowel or bladder control, reactive anxiety/depression secondary to chronic pain, left fourth two fracture, L2-L3 and L4-5 microdiscectomy, right-sided, and left lid droop. Per the submitted records, prior treatment has included surgery and medications. A request has been submitted for acupuncture one to two times per week for eight weeks, a quantity of sixteen sessions.

The MTUS Acupuncture Guidelines note that acupuncture has not been found to be effective in the management of back pain, based on high quality studies, but there is anecdotal evidence to its success. The records submitted for review do not document significant progressive neurological deficits. **The requested acupuncture one to two times per week for eight weeks, a quantity of sixteen sessions is not medically necessary and appropriate.**

- 6) **Regarding the request** acupuncture one to two times per week for eight weeks, a quantity of sixteen sessions,

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

The Claims Administrator based its decision on the MTUS Guidelines, chapter 8-14 (no specific guideline or page cited). The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Low Back Chapter, Preoperative testing, which is not part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 7/02/10. The submitted medical records note right lower extremity pain and weakness and buttock pain. The employee's diagnoses include new lumbar sprain with instability, bilateral lower extremity radiculopathy, right more than left, with right-sided weakness with walking and a suggestion of low of bowel or bladder control, reactive anxiety/depression secondary to chronic pain, left fourth two fracture, L2-L3 and L4-5 microdiscectomy, right-sided, and left lid droop. Per the submitted records, prior treatment has included surgery and medications. A request has been submitted for chest x-ray.

The Official Disability Guidelines note preoperative testing including chest x-ray is often performed before surgical procedures and these investigations could be helpful to stratify this, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medically necessity. Per the guidelines, decisions to order preoperative testing should be guided by the patient's clinical history, comorbidities and physical examination findings. The submitted records do not indicate a specific rationale for a chest x-ray and records do not indicate the employee is a smoker nor has pulmonary

disease. **The requested chest x-ray 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

/srb

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.