
Notice of Independent Medical Review Determination

Dated: 8/19/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/2/2013
Date of Injury: 7/5/2011
IMR Application Received: 7/10/2013
MAXIMUS Case Number: CM13-0001128

- 1) MAXIMUS Federal Services, Inc. has determined the request for a neurosurgeon consult for lumbar spine **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ambien (10 mg) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a point of care urine drug screen quarterly test **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a complete blood count (CBC) quarterly test **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a creatine phosphokinase (CPK) quarterly test **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for a C reactive protein quarterly test **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for a Chem 8 quarterly test **is not medically necessary and appropriate.**

- 8) MAXIMUS Federal Services, Inc. has determined the request for a hepatic function quarterly test **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for an arthritis panel quarterly test **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/10/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/11/2013. 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 a neurosurgeon consult for lumbar spine **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ambien (10 mg) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a point of care urine drug screen quarterly test **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a complete blood count (CBC) quarterly test **is not medically necessary and appropriate.**
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- 7) MAXIMUS Federal Services, Inc. has determined the request for a Chem 8 quarterly test **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for a hepatic function quarterly test **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for an arthritis panel quarterly test **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 Internal Medicine 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.

PRIOR SURGERY/PROCEDURES:

- 02/13/12 [REDACTED] M.D.; L4-5 epidural steroid injection [AME report notes 1 week of relief]
- 04/12/13 [REDACTED] M.D.; L4-L5 epidural therapeutic injection with fluoroscopy
- 05/17/13 [REDACTED] M.D.; Right transforaminal L4-5 epidural therapeutic injection with fluoroscopy

MEDICAL RECORD SUMMARY:

- 10/10/12 [REDACTED] MD; AME Re-Examine; Dr. [REDACTED] saw the patient in April 2012 and recommended a lumbar epidural steroid injection. Since then, he has had 1 injection. This has been beneficial. Dr. [REDACTED] recommended a second injection.
- 03/28/13 R. [REDACTED] M.D.; Orthopedic AME re-examination. Has had one epidural with good response (1 week of relief) Recommends continuation of epidurals for a full series, follow up in 2 months. Temporarily totally disabled pending re-evaluation
- 05/31/13 [REDACTED] F.N.P.-C., [REDACTED] M.D.; Report. Usual complaints of pain in lumbar spine with radiation down right lower extremity to the bottom of the foot, VAS 4/10 increasing to 5.5/10 in leg. Had 3 epidural injection with Dr. [REDACTED] the last on 05/17/13 with partial effectiveness for relief of back pain, but not right leg pain. Exam: Upright posture today, non antalgic gait. Diagnoses: Lumbar spine degenerative disc disease. Plan: Refill Ibuprofen 800mg 3x/day as needed #90, Norco 10/325mg 2x/day as needed for breakthrough pain, Gabapentin 600mg 2xDay for neuropathic symptomatology #60 and Ambien 10mg at bedtime as needed for insomnia, all meds with one additional refill. Request neurosurgeon consult in regard to lumbar spine, has had 3 injections and therapy, has failed conservative treatment. Follow up 4-6 weeks. Total temporary disability.
- 05/31/13 [REDACTED]; Consultation Order form: Consultation requested with neurosurgeon for lumbar spine.
- 06/25/13 [REDACTED] M.D. Request for authorization (exam date 05/31/13). Request: Re-exam with [REDACTED] M.D. scheduled 07/08/13. Neurosurgeon consult due to failed conservative care re Lumbar spine. Quarterly POC-urine drug screen. Quarterly lab panels (CBC, CPK, CRP, CHEM 8, Hepatic panel and Arthritis panel) Written prescription: Norco 10/325mg #60, Gabapentin 600mg #60, Ambien 10mg #30 and Ibuprofen 800mg #90

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:

- Applications (2) for Independent Medical Review
- Utilization Review Documentation by [REDACTED] (dated 7/2/13)
- Medical Records by [REDACTED], M.D. (dated 7/10/12 to 3/28/13)
- EMG/NCS Patient Questionnaire and Report (dated 5/8/12)
- Medical Records by [REDACTED], M.D. (dated 8/7/12)
- Medical Records by [REDACTED], M.D. (dated 1/15/13 to 5/17/13)
- Lab Reports by [REDACTED] (dated 6/5/12 to 4/23/13)
- Acupuncture Notes by [REDACTED], L.AC (dated 1/8/13 to 1/31/13)
- Medical Records by [REDACTED], M.D. (dated 4/9/12 to 5/31/13)
- Medical Record by [REDACTED] (dated 4/18/13)
- Imaging Report by [REDACTED] (dated 8/21/12)
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) – Consultations

- Official Disability Guidelines (ODG) – Treatment Index, Zolpidem/Ambien section and Urine Drug Testing section
- Chronic Pain Medical Treatment Guidelines (2009), pages 43 and 78

1) Regarding the request for a neurosurgeon consult:

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) Guidelines, 2nd Edition, (2004) – page 127, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined that the MTUS does not appropriately address the requested treatment. 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 back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for a neurosurgeon consult.

The ACOEM guideline recommends MRI and neurosurgical consultation for possible surgical lesion. The MRI report submitted and reviewed, dated August 2012, does not demonstrate a lesion that would require surgical intervention. The medical records submitted do not present any obvious neurological deficits. The request for a neurosurgeon consult is not medically necessary and appropriate.

2) Regarding the request for Ambien (10 mg):

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) – Treatment Index, Zolpidem/Ambien section, which is a medical treatment guideline that is not part 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:

The employee sustained a back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for Ambien (10 mg).

The ODG indicates long-term use of Ambien is not recommended due to adverse side effects and interactions with other medications. The request for Ambien (10 mg) is not medically necessary and appropriate.

3) Regarding the request for a point of care urine drug screen quarterly test:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 43 and 78, which are part of the MTUS. The Claims Administrator also cited the Official Disability Guidelines (ODG) – Treatment Index, Urine Drug Testing section, which is a medical treatment guideline that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for a point of care urine drug screen quarterly test.

The MTUS Chronic Pain guideline indicates urine drug screening is performed if there are issues involving abuse or addiction. The medical records submitted and reviewed do not report any of these issues. The guideline criteria are not met. The request for a point of care urine drug screen quarterly test is not medically necessary and appropriate.

4) Regarding the request for a CBC quarterly test:

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) – page 79, which is part 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:

The employee sustained a back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for a CBC quarterly test.

The request for quarterly CBC's is not supported by the documentation in this case. The requesting provider did not submit any guideline or justifiable reason to support the request. The request for a CBC quarterly test is not medically necessary and appropriate.

5) Regarding the request for a CPK quarterly test:

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) Guidelines, 2nd Edition, (2004) – page 79, which is part 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:

The employee sustained a back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for a CPK quarterly test.

The request for quarterly CPK's is not supported by the documentation in this case. The requesting provider did not submit any guideline or justifiable reason to support the request. The request for a CPK quarterly test is not medically necessary and appropriate.

6) Regarding the request for a C reactive protein quarterly test:

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

The Claims Administrator based its decision on the the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, (2004) – page 79, which is part 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:

The employee sustained a back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for a C reactive protein quarterly test.

The request for a C reactive protein quarterly test is not supported by the documentation in this case. The requesting provider did not submit any guideline

or justifiable reason to support the request. The request for a C reactive protein quarterly test is not medically necessary and appropriate.

7) Regarding the request for a Chem 8 quarterly test:

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

The Claims Administrator based its decision on the the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, (2004) – page 79, which is part 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:

The employee sustained a back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for a Chem 8 quarterly test.

The request for a Chem 8 quarterly test is not supported by the documentation in this case. The requesting provider did not submit any guideline or justifiable reason to support the request. The request for a Chem 8 quarterly test is not medically necessary and appropriate.

8) Regarding the request for a Hepatic function quarterly test:

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

The Claims Administrator based its decision on the the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, (2004) – page 79, which is part 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:

The employee sustained a back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for a Hepatic function quarterly test.

The request for a Hepatic function quarterly test is not supported by the documentation in this case. The requesting provider did not submit any guideline or justifiable reason to support the request. The request for a Hepatic function quarterly test is not medically necessary and appropriate.

9) Regarding the request for an arthritis panel quarterly test:

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

The Claims Administrator based its decision on the the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, (2004) – page 79, which is part 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:

The employee sustained a back injury on 7/5/11 and has experienced chronic back and leg pain. As of the date of the utilization review decision, the employee is total temporary disabled. Treatment to date has included medication, 3 injections and unspecified therapy. A request was submitted for an arthritis panel quarterly test.

The request for an arthritis panel quarterly test is not supported by the documentation in this case. The requesting provider did not submit any guideline or justifiable reason to support the request. The request for an arthritis panel quarterly test 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

/dj

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.