

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 11/6/2013

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/1/2013
Date of Injury: 6/11/2012
IMR Application Received: 7/23/2013
MAXIMUS Case Number: CM13-0003174

- 1) MAXIMUS Federal Services, Inc. has determined the request for one (1) EMG /NCS of bilateral upper and lower extremities **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ultram ER 150mg #30 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Perocet 5/325mg **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Diclofenac XR 100mg #30 **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20mg #60 **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for a one (1) month trial of a TENS unit **is medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for one (1) lumbar sacral orthosis (LSO) back brace **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/23/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 one (1) EMG /NCS of bilateral upper and lower extremities **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ultram ER 150mg #30 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Perocet 5/325mg **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Diclofenac XR 100mg #30 **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20mg #60 **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for one (1) month trial of a TENS unit **is medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for one (1) lumbar sacral orthosis (LSO) back brace **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 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:

NO Clinical Summary was provided with the Utilization Determination Review dated 7/1/2013.

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 07/23/2013)
- Utilization Review Determination [REDACTED] (dated 07/01/2013)
- Employee Medical Records [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for one (1) EMG /NCS of bilateral upper and lower extremities:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) guidelines, 2004, 2nd Edition, Neck and Upper Back Complaints, Chapter 8, Special Studies and Diagnostic and Treatment Considerations, pg. 178, Forearm, Wrist and Hand Complaints, Chapter 11, pgs. 260-262, and Low Back Complaints, Chapter 12, Special Studies and Diagnostic and Treatment Considerations, pg. 303, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 6/11/2012. The medical report of 6/5/13 documents that the employee is experiencing pain in the head, neck, left shoulder, low back, and left leg, and the physical exam showed positive straight leg raise test on the left in the seated and supine position at 45 degrees and diminished sensation in the left L5 and S1 dermatomes. The medical report of 7/3/13, documents that the employee experienced numbness and weakness in the right and left hands. The medical records provided for review indicate treatments have included oral analgesic medication and lower back surgery. The request is for one (1) EMG/NCS of bilateral upper and lower extremities.

ACOEM Guidelines indicate that Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in individuals with neck or arm symptoms, or both, lasting more than three or four weeks, and that appropriate electrodiagnostic studies (EDS) may help differentiate between carpal tunnel syndrome (CTS) and other conditions, such as cervical radiculopathy. The medical records provided for review indicate that the employee does have neck pain, low back pain, and radicular symptoms in the upper extremities and the left lower extremity for more than three or four weeks. The guideline criteria have been met. The request for one (1) EMG/NCS of bilateral upper and lower extremities is medically necessary and appropriate.

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

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Tramadol, pg. 82, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 6/11/2012. The medical report of 6/5/13 documents that the employee complained of pain in the head, neck, left shoulder, low back, and left leg, and the physical exam showed positive straight leg raise test on the left in the seated and supine position at 45 degrees and diminished sensation in the left L5 and S1 dermatomes. The medical report of 7/3/13, documents that the employee complained of numbness and weakness in the right and left hands. The medical records provided for review indicate treatments have included oral analgesic medication and lower back surgery. The request is for Ultram ER 150mg #30.

Chronic Pain Medical Treatment Guidelines indicate that opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). The medical records provided for review indicate that the employee continued to have inadequate control of pain. The guideline criteria have been met. The request for Ultram ER 150mg #30 is medically necessary and appropriate.

3) Regarding the request for Percocet 5/325mg:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids for chronic pain, pg. 80, and Opioid Classifications: Short-acting/Long-acting opioids, pg. 75, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 6/11/2012. The medical report of 6/5/13 documents that the employee complained of pain in the head, neck, left shoulder, low back, and left leg, and the physical exam showed positive straight leg raise test on the left in the seated and supine position at 45 degrees and diminished sensation in the left L5 and S1 dermatomes. The medical report of 7/3/13, documents that the employee complained of numbness and weakness in the right and left hands. The medical records provided for review indicate

treatments have included oral analgesic medication and lower back surgery. The request is for Percocet 5/325mg.

Chronic Pain Medical Treatment Guidelines indicate that Percocet is considered a short acting opioids and are seen as an effective method in controlling chronic pain, and they are often used for intermittent or breakthrough pain. The guidelines also indicate that opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). The medical records provided for review indicate that the employee had been taking Lyrica with some benefit for neuropathic pain, and would take the Percocet for better pain control at night. The guideline criteria have been met. The request for Percocet 5/325mg is medically necessary and appropriate.

4) Regarding the request for Diclofenac XR 100mg #30:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Anti-inflammatory medications, pg. 22, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 6/11/2012. The medical report of 6/5/13 documents that the employee complained of pain in the head, neck, left shoulder, low back, and left leg, and the physical exam showed positive straight leg raise test on the left in the seated and supine position at 45 degrees and diminished sensation in the left L5 and S1 dermatomes. The medical report of 7/3/13, documents that the employee complained of numbness and weakness in the right and left hands. The medical records provided for review indicate treatments have included oral analgesic medication and lower back surgery. The request is for Diclofenac XR 100mg #30.

Chronic Pain Medical Treatment Guidelines indicate that anti-inflammatory medications are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be justified. The guidelines also state that a comprehensive review of clinical trials on the effectiveness and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective, non-steroidal anti-inflammatory drugs (NSAIDs) in chronic low back pain. The medical records provided for review indicate that the employee had a lower back fusion four months prior, and this medication was prescribed for the purpose of reducing pain and improving function. The guideline criteria have been met. The request for Diclofenac XR 100mg #30 is medically necessary and appropriate.

5) Regarding the request for Prilosec 20mg #60:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, pgs. 68-69, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 6/11/2012. The medical report of 6/5/13 documents that the employee complained of pain in the head, neck, left shoulder, low back, and left leg, and the physical exam showed positive straight leg raise test on the left in the seated and supine position at 45 degrees and diminished sensation in the left L5 and S1 dermatomes. The medical report of 7/3/13, documents that the employee complained of numbness and weakness in the right and left hands. The medical records provided for review indicate treatments have included oral analgesic medication and lower back surgery. The request is for Prilosec 20mg #60.

Chronic Pain Medical Treatment Guidelines states that the risk for gastrointestinal events are (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The medical records provided for review did not show evidence that the employee was at an intermediate risk for GI events. The guideline criteria have not been met. The request for Prilosec 20mg #60 is not medically necessary and appropriate.

6) Regarding the request for a one (1) month trial of a TENS unit:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, TENS, pg. 116, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 6/11/2012. The medical report of 6/5/13 documents that the employee complained of pain in the head, neck, left shoulder, low back, and left leg, and the physical exam showed positive straight leg raise test on the left in the seated and supine position at 45 degrees and diminished sensation in the left L5 and S1 dermatomes. The medical report of 7/3/13, documents that the employee complained of numbness and weakness in the right and left hands. The medical records provided for review indicate

treatments have included oral analgesic medication and lower back surgery. The request is for a one (1) month trial of a TENS unit.

The Chronic Pain Guidelines indicate that a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Criteria for the use of TENS includes; documentation of pain of at least three months duration and evidence that other appropriate pain modalities have been tried (including medication) and failed. The medical records provided for review indicate that appropriate pain modalities have been tried (including medication) and failed. The guideline criteria have been met. The request for a one (1) month trial of a TENS unit is medically necessary and appropriate.

7) Regarding the request for one (1) lumbar sacral orthosis (LSO) back brace:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) guidelines, 2004, 2nd Edition, Low Back Complaints, pg. 301, which is part of the California Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines (ODG), Lumbar supports, which is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 6/11/2012. The medical report of 6/5/13 documents that the employee complained of pain in the head, neck, left shoulder, low back, and left leg, and the physical exam showed positive straight leg raise test on the left in the seated and supine position at 45 degrees and diminished sensation in the left L5 and S1 dermatomes. The medical report of 7/3/13, documents that the employee complained of numbness and weakness in the right and left hands. The medical records provided for review indicate treatments have included oral analgesic medication and lower back surgery. The request is for one (1) lumbar sacral orthosis (LSO) back brace.

ACOEM Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief, and does not address post-operative indications for lumbar bracing. Official Disability Guidelines for post-operative lumbar bracing states that the use of post-operative lumbar bracing is under study; there may be special circumstances (multilevel cervical fusion, thoracolumbar unstable fusion, non-instrumented fusion, mid-lumbar fractures, etc.) in which some external immobilization might be desirable. Medical records provided for review did not indicate any suspicion of unstable fusion or non-instrumented fusion. The guideline criteria have not been met. The request for one (1) lumbar sacral orthosis (LSO) back brace 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.