
Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]

[REDACTED]

[REDACTED]

Date of UR Decision:

[REDACTED] 7/19/2013

Date of Injury:

6/2/2010

IMR Application Received:

8/2/2013

MAXIMUS Case Number:

CM13-0006386

- 1) MAXIMUS Federal Services, Inc. has determined the request for **MRI lumbar spine without contrast is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **MRI left shoulder without contrast is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **MRI right shoulder without contrast is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **EMG bilateral lower extremities is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **back support is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **lumbar traction unit is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/29/2013. 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 **MRI lumbar spine without contrast is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **MRI left shoulder without contrast is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **MRI right shoulder without contrast is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **EMG bilateral lower extremities is not medically necessary and appropriate.**
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- 6) MAXIMUS Federal Services, Inc. has determined the request for **lumbar traction unit 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 Orthopedic Surgeon and is licensed to practice in Michigan, New England and 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:

This claimant is a 52-year-old female with a reported date of injury of 05/07/2007 to 06/02/2010. The mechanism of injury is described as repetitive office work. On 11/07/2012, she complained of worsening headaches from her neck pain. She described pain to the left shoulder, bilateral hips, and left knee. On 12/17/2012, x-rays of the hands showed normal bone mineralization with no fracture. X-rays of the knees showed mild degenerative changes of the medial compartment of the left knee and the patellofemoral articulation with narrowing. Wrist x-rays were within normal limits but did demonstrate mild degenerative changes at the carpal metacarpal joint of the right wrist. MRI of the cervical spine revealed at C5-6 there was disc desiccation with annular bulging beyond the endplate margin contributing to mild central canal and biforaminal stenosis left greater than right. There was contact with the exiting left C6 nerve root but there was no cord compression. She was seen for an orthopedic evaluation on 07/11/2013. It was noted then that she had undergone EMG and nerve conduction

studies and was diagnosed with left carpal tunnel syndrome and left cubital tunnel syndrome. She subsequently was taken to surgery for those diagnoses. Reflexes to the upper extremities were all rated at 2+ and muscle testing for the cervical spine was rated at 5/5. Sensation was decreased with pain in a C6 distribution to the left. Shoulder range of motion was not measured. On 08/13/2013, a supplemental medical-legal report and appeal was submitted by the treating provider indicating the patient had radiculopathy in the lower extremities with numbness, tingling, and weakness and described low back pain with radiculopathy. She also reported decreased dermatomal sensation with pain noted over the bilateral L5 dermatomes mainly on the left. Diagnoses included cervical sprain, cervical radiculopathy, lumbar sprain, lumbar radiculopathy, bilateral shoulder impingement, bilateral elbow tendinitis, status post left cubital tunnel release, and bilateral wrist tendinitis, status post left carpal tunnel release. The plan at that time was to request an MRI of the lumbar spine without contrast, MRI of the left shoulder without contrast, MRI of the right shoulder without contrast, EMG to the bilateral lower extremities, back support, and lumbar traction unit.

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
- No medical records were provided by the Claims Administrator
- Medical Records from: Claims Administrator

1) Regarding the request for MRI lumbar spine without contrast:

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) Guidelines Chapter 12, low back, pg 303, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pages 303-305, Special Studies and Diagnostic and Treatment Considerations, which is a part of the MTUS; and the Official Disability Guidelines (ODG): Low Back chapter, MRI, which is not a part of the MTUS.

Rationale for the Decision

The ACOEM guidelines indicate that unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging, per MTUS/ACOEM, will result in false positive findings, such as disc bulges, that are not the source of painful symptoms and do not warrant surgery. A review of the records indicates that when this employee was seen for initial comprehensive

orthopedic evaluation on 07/11/2013, the employee did describe back pain. Supine straight leg raise at that time elicited no back pain and sitting straight leg raise was stated to be similar. The employee had 5/5 strength in the bilateral lower extremities but did have reported decreased sensation to the left L5 distribution. However, from 07/11/2013 through the last medical-legal report of 08/13/2013, the records do not describe significant current conservative care for this employee. They do not indicate that plain x-rays have been obtained of the lumbar spine. The records do not indicate this employee would be a surgical candidate at this time. There is a lack of documentation of significant current conservative evaluation, lack of documentation of current conservative care, and lack of documentation of a psychosocial evaluation. Therefore, Official Disability Guidelines is utilized in support of MTUS/ACOEM Low Back Chapter which indicates that for uncomplicated low back pain with radiculopathy an MRI may be considered reasonable after at least 1 month of conservative therapy or sooner if severe or progressive neurological deficits are noted. The records do not describe severe or progressive neurological deficits and do not describe significant current conservative care. **The request for MRI lumbar spine without contrast is not medically necessary and appropriate.**

2) **Regarding the request for MRI left shoulder without contrast:**

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), Chapter 9, shoulder, pg. 209, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pages 207-209, Special Studies and Diagnostic and Treatment Considerations, which is a part of the MTUS.

Rationale for the Decision:

A review of the records indicates that the initial comprehensive orthopedic evaluation dated 07/11/2013 failed to describe left shoulder range of motion. However, it was noted that there was no tenderness noted around the shoulder, although impingement and Hawkins signs were positive bilaterally. The submitted records do not indicate that the employee has had recent x-ray imaging of the left shoulder. MTUS/ACOEM guidelines indicate that the primary criteria for ordering imaging studies are emergence of a red flag, physiological evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or for clarification of the anatomy prior to invasive procedure. Imaging may also be considered for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, in cases when surgery is being considered for a specific anatomical defect such as full thickness rotator cuff tear, or to further evaluate the possibility of potentially serious pathology such as a tumor. The submitted records do not indicate this treatment provider is suspicious of a tumor or significant pathology to the left shoulder. The records do not provide a complete physical exam of the left shoulder after 07/11/2013 and do not indicate the current status of this

employee in regard to the left shoulder. The records do not indicate significant current conservative care in regard to the left shoulder as recommended by MTUS/ACOEM. **The request for MRI left shoulder without contrast is not medically necessary and appropriate.**

3) Regarding the request for MRI right shoulder without contrast:

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), Chapter 9, shoulder, pg. 209, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pages 207-209, Special Studies and Diagnostic and Treatment Considerations, which is a part of the MTUS.

Rationale for the Decision:

The initial comprehensive orthopedic evaluation dated 07/11/2013 failed to describe right shoulder range of motion. However, it was noted that there was no tenderness noted around the shoulder, although impingement and Hawkins signs were positive bilaterally. The submitted records do not indicate that the employee has had recent x-ray imaging of the right shoulder. MTUS/ACOEM guidelines indicate that the primary criteria for ordering imaging studies are emergence of a red flag, physiological evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or for clarification of the anatomy prior to invasive procedure. Imaging may also be considered for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, in cases when surgery is being considered for a specific anatomical defect such as full thickness rotator cuff tear, or to further evaluate the possibility of potentially serious pathology such as a tumor. The submitted records do not indicate this treatment provider is suspicious of a tumor or significant pathology to the left shoulder. The records do not provide a complete physical exam of the right shoulder after 07/11/2013 and do not indicate the current status of this employee in regard to the right shoulder. The records do not indicate significant current conservative care in regard to the right shoulder as recommended by MTUS/ACOEM. **The request for MRI right shoulder without contrast is not medically necessary and appropriate.**

4) Regarding the request for EMG bilateral lower extremities :

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), Chapter 12, Low Back, pg 303, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pages 303-305, Special Studies and Diagnostic and Treatment Considerations, which is a part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM guidelines indicate that electromyography including H-reflex test may be useful to identify subtle focal neurological dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. A review of the records indicates the employee had decreased sensation in the left L5 distribution and complained of low back pain going into the lower extremities. The treating physician, in a note dated 07/26/2013, indicated the employee “does describe radiculopathy in the lower extremities with numbness, tingling, and weakness along with lower back pain.” Thus, there does not appear to be a subtle focal neurological dysfunction as described by MTUS/ACOEM, but the employee does have a neurological dysfunction that is attributable to the left L5 region. Therefore, radiculopathy has been established by the clinical exam, and the rationale for proceeding with an EMG to the bilateral lower extremities at this time has not been demonstrated. **The request for EMG bilateral lower extremities is not medically necessary and appropriate.**

5) Regarding the request for back support:

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), Chapter 12, Low Back, pg. 301, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) page 301, lumbar supports, which is a part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The medical records provided for review do not describe this employee as being in the acute phase of treatment and do not indicate that the employee has significant instability for which a lumbar support would be useful. Furthermore, the records do not describe the employee’s current clinical status, as the last clinical exam was dated 07/11/2013. **The request for back support is not medically necessary and appropriate.**

6) Regarding the request for lumbar traction unit:

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

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) page 300, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pages 298-300, Physical Methods, which is a part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM guidelines indicate that traction has not been proven to be effective for lasting relief in treating low back pain. The guidelines indicate that because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. The medical records provided for review do not indicate that this employee has significant issues at this time for which traction might be useful and traction is not supported by MTUS/ACOEM. **The request for lumbar traction unit 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.