

Independent Medical Review Final Determination Letter

[REDACTED]
 [REDACTED]
 [REDACTED]
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Dated: 12/31/2013

IMR Case Number:	CM13-0017651	Date of Injury:	08/13/2004
Claims Number:	[REDACTED]	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	08/28/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED], MD		
Treatment(s) in Dispute Listed on IMR Application:	BILATERAL TRANSFORAMINAL BLOCK, ONE LEVEL, BILATERAL TRANSFORAMINAL BLOCK, TWO LEVEL, AND EPIDUROGRAPHY		

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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, Ohio, and Pennsylvania. 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

NO MEDICAL RECORDS RECEIVED FROM THE CLAIMS ADMINISTRATOR

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 08/13/2004. The primary reference diagnosis is lumbar disc displacement. The patient previously underwent a lumbar epidural injection on 07/31/2013 for low back pain with right L4 and L5 radicular pain. A previous epidural injection provided approximately 70% relief of pain. The patient also underwent bilateral facet injections at C6 through T2 on 07/17/2013.

A prior physician review indicated that the request for bilateral transforaminal blocks and epidurography were not medically necessary.

A physician supplemental note of 06/23/2013 notes that other than facet hypertrophy, the prior lumbar MRI was within normal limits.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Bilateral transforaminal block, one level is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS, Epidural Steroid Injections (ESIs) and (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Epidural Steroid Injections, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines, section on epidural steroid injections, states, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing...In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6-8 weeks." The medical records at this time do not clearly indicate a specific level or levels at which the physical examination findings corroborate with diagnostic findings. Additionally, the records contain only limited information regarding the location and efficacy of prior epidural injections. For these reasons, the patient does not meet the criteria for the requested transforaminal injection treatment, and therefore this should be considered not medically necessary.

2. Bilateral transforaminal block, two levels is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS, Epidural Steroid Injections (ESIs) and (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Epidural Steroid Injections, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines, section on epidural steroid injections, states, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing...In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6-8 weeks." The medical records at this time do not clearly indicate a specific level or levels at which the physical examination findings corroborate with diagnostic findings. Additionally, the records contain only limited information regarding the location and efficacy of prior epidural injections. For these reasons, the patient does not meet the criteria for the requested transforaminal injection treatment, and therefore this should be considered not medically necessary.

3. Epidurography is not medically necessary and appropriate.

The Claims Administrator based its decision on: Not clear from the UR Determination.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 12/Low Back and Page 309, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The ACOEM guidelines, chapter 12 on the low back, page 309, recommend for imaging, "CT or MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative...Myelography or CT myelography for preoperative planning...Not recommended: Discography or CT discography." The guidelines do not document an indication for epidurography, which is investigational in the peer review literature. Overall, the medical records and treatment guidelines do not support an indication for this request. This request is not medically necessary.

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.

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