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**Notice of Independent Medical Review Determination**

Dated: 10/3/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/3/2013  
Date of Injury: 6/27/1995  
IMR Application Received: 7/18/2013  
MAXIMUS Case Number: CM13-0001985

- 1) MAXIMUS Federal Services, Inc. has determined the request for a thoracic lumbar injection **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/22/2013. 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 thoracic lumbar injection **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 Anesthesiology and Pain Management 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 3, 2013:

Operative report dated 12/05/11 indicates that the claimant underwent placement of Tuohy needle into caudal epidural space under fluoroscopy, placement of radiopaque catheter to the left side at L5-S1, epidurogram to assess adequate flow of medication under fluoroscopy via catheter and epidural injection with local anesthetics and anti-inflammatories.

Operative report dated 01/19/12 indicates that the claimant underwent aspiration of CSF, intrathecal injection with local anesthetic and lumbar myelogram under fluoroscopy.

Operative report dated 03/05/12 indicates that the claimant underwent aspiration of CSF, contrast injection into the CSF (myelogram to assess adequate flow of medication) and injection of local anesthetic anti-inflammatory into CSF under fluoroscopy.

History and physical report dated 06/26/12 indicates the claimant had temporary implant for trial of spinal cord stimulator back on 06/20/12. With the use of stimulator the claimant is 60 percent more mobile due to decrease of pain. The provider states the claimant is a candidate for permanent implant. The claimant has come to have the spinal cord stimulator removed. The claimant has been complaining of weakness of the right upper extremity and deep ache of the deltoid muscles. The claimant has significant improvement of low back pain with a trial of spinal cord stimulator. The claimant's

medications include Norco, MSIR, Trazodone, Zanaflex, and Lyrica. The provider states to remove the temporary two leads that were implanted, provider recommends permanent resume lead implant with pulse generator. The claimant was taken to the procedure room and stimulators were removed atraumatically.

Operative report dated 07/26/12 indicates the claimant underwent implant of two Medtronic 8-contact compact leads under fluoroscopy and implant of a multi program neurostimulator restore prime pulse generator to right buttock area. The provider states the claimant has successfully been trialed for two 8-contact leads spinal cord stimulator back on 06/20/12. The claimant had greater than 50 percent diminution of pain. The claimant comes for permanent implant of both spinal cord stimulator and a pulse generator.

Operative report dated 08/13/12 indicates that the claimant underwent percutaneous attempted epidural movement of implanted spinal cord stimulation, thoracic epidural injection, and thoracic epidurogram to assess adequate flow of medication. The provider states the claimant's left lead is in good position and the claimant will try percutaneously with #14 gauge needle and another spinal cord stimulator lead try to push the leads from the left to the right side today. The provider states if this does not help, the provider will request implant of paddle lead, which will need a laminotomy so that there would be no movement of these leads. The provider going to request that the stimulator paddle leads be placed as soon as possible since the claimant did go through detox programs to be able to have the spinal cord stimulator trial.

Follow up visit report dated 04/22/13 indicates that the claimant has left chest ache like a bruise below left breast. There is tenderness and it hurt at times more with position of chest. Associated symptoms include chest pain, lightheadedness, fatigue, leg pain, and weakness. The claimant also complains of neck and back pain, muscle weakness and muscle cramps. The provider recommends medications, lab test, echo with Doppler, and cardiovascular stress test.

Evaluation report dated 05/15/13 indicates that the claimant has pain rated 7/10. The provider recommends medications refill and revision of the leads to move one level down.

**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
- Utilization Review from Claims Administrator
- Medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

## 1) Regarding the request for a thoracic lumbar injection:

### 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) pg. 46 which is part of the Medical Treatment Utilization Schedule (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 work-related injury on June 27, 1995 to the lower back. Medical records provided for review indicate diagnoses of chronic low back pain, postlaminectomy syndrome arachnoiditis, status post spinal cord stimulator placement with two 8 contact leads. The request is for a thoracic lumbar injection.

The MTUS-Chronic Pain guidelines do indicate criteria for epidural steroid injections. However, the medical records reviewed lack documentation in regards to the dermatome level where the injection will be injected. Furthermore, the provider did not present adequate documentation in regards to whether or not the patient's chest pain is radicular or at what level the procedure is to be done other than pain of the breast going laterally and anteriorly. Given the lack of documentation in the medical records provided, the request for a thoracic lumbar injection **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  
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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.