

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/18/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/2/2013
Date of Injury:	1/19/2013
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0003830

- 1) MAXIMUS Federal Services, Inc. has determined the request for pain management consultation to include a cervical epidural injection **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. 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 pain management consultation to include a cervical epidural 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 Orthopaedic Surgery, 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:

**Radiology report MRI of the cervical spine dated 05/02/13 reveals cervical spondylosis at C3-4 through C6-7 discs. At C3-4, there is 2 mm anterolisthesis of C3 on C4. At C4-5, there is minimal anterolisthesis of C4 on C5 with uncovertebral spurring with right moderate neuroforaminal narrowing. There is 2.5 mm posterior osteophyte disc complex at C5-6 and 2 mm at C6-7, both with mild neuroforaminal narrowing bilaterally.**

**Primary treating physician's orthopedic spine surgery narrative report dated 06/03/13 indicates that the claimant complains of daily neck pain which increases with activity and radiates down to the left upper extremity. Cervical spine exam reveals paracervical and paraspinous tenderness, decreased range of motion, local pain with orthopedic testing, and relief with cervical distraction test. Neurological exam reveals intact sensation, normal strength, and symmetric reflexes in upper extremities. X-rays dated 03/18/13 reveals severe disc collapse at C5-6 with foraminal stenosis. MRI of the cervical spine dated 05/02/13 is reviewed. The provider recommends pain management consultation for cervical epidural steroid injection. The claimant will continue with the approved physical therapy.**

**Primary treating physician's orthopedic spine surgery letter of medical necessity dated 06/20/13 indicates that the claimant's radiculopathy subjectively and on physical exam combined with diagnostic imaging showing stenosis meet the criteria to proceed with epidural injection.**

### **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 Determination from Claims Administrator
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request for pain management consultation to include a cervical epidural injection:**

#### 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), Chapter 7, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Epidural Steroid Injection 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 relied on the Chronic Pain Medical Treatment Guidelines (2009), pg. 46, which is part of the MTUS. The Expert Reviewer also cited the ACOEM Guidelines, pages 89-92, which are part of the MTUS.

#### Rationale for the Decision:

The employee was injured in a fall on 01/19/2013. The employee has been treated for left proximal humerus and shaft open reduction, internal fixation. The employee is experiencing cervical spine pain and left shoulder pain. The request is for pain management consultation to include a cervical epidural injection.

The ACOEM guideline indicates a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. Collaboration with the employer and insurer is necessary to design an action plan to address multiple issues, which may include arranging for an external case manager, the physician can function in this role. The MTUS Chronic Pain guideline also indicates that for the use of epidural steroid injections, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Medical records submitted and reviewed document no objective findings of any neurological, sensory, or motor deficits and did not indicate the presence of radiculopathy. The MTUS Chronic Pain guideline criteria have not been met. The request for pain management consultation to include a cervical epidural 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  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

/ldh

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.