

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 11/26/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/15/2013
Date of Injury:	1/7/2010
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004332

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 **transforaminal lumbar epidural steroid injection bilaterally at S1 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 **interventional pain management consultation is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/7/2013. 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 1 **transforaminal lumbar epidural steroid injection bilaterally at S1 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 **interventional pain management consultation is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The 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.

Expert Reviewer Case Summary:

The patient has a diagnosis of bilateral lumbar radiculopathy and chronic pain. The MRI of L-spine from 10/20/11 only described bulging discs at L5-1 and L4-5. Examination showed decreased sensation bilaterally in the S1 dermatomal distribution, negative SLR bilaterally, normal gait and strength. The request is for f/u pain management and lumbar epidural steroid injection bilaterally at L5 and S1 levels. Mechanism of injury is described as trip and fall while carrying a sail falling onto his buttocks on 1/7/2010. The patient has had lumbar medial branch blocks without success and failed to improve with conservative care.

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
- Employee Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for 1 transforaminal lumbar epidural steroid injection bilaterally at S1:

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

The Claims Administrator did not cite any evidence-based guidelines in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 46-47, which are part of the MTUS.

Rationale for the Decision:

According to the MTUS guidelines for epidural steroid injections (ESIs), radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The medical records provided for review indicate that the employee's MRIs do not show any abnormalities that can cause radiculopathy. Bulging discs are described, but bulging discs are normal findings and do not cause radiculopathy. There is also a lack of any electrodiagnostic findings to support radiculopathy. MTUS requires hard evidence including MRI findings that would corroborate radiculopathy such as disc herniation or stenosis or other nerve root problems. **The request for 1 transforaminal lumbar epidural steroid injection bilaterally at S1 is not medically necessary and appropriate.**

2) Regarding the request for 1 interventional pain management consultation:

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

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, (2004), page 127.

Rationale for the Decision:

The ACOEM guidelines cited above state that an individual may be referred to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The medical records provided for review indicate that the employee suffers from chronic pain and follow-up visitations with the pain management specialist should be allowed. In this case, pain management involvement is quite consistent with ACOEM. **The request for 1 interventional pain management consultation is 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.