**MAXIMUS FEDERAL SERVICES, INC.**
Independent Medical Review
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MAXIMUS Federal Services

## Notice of Independent Medical Review Determination

Dated: 11/26/2013

[redacted]

[redacted]

| | |
|---|---|
| Employee: | [redacted] |
| Claim Number: | |
| Date of UR Decision: | 7/22/2013 |
| Date of Injury: | 10/11/2008 |
| IMR Application Received: | 7/31/2013 |
| MAXIMUS Case Number: | CM13-0004903 |

1) MAXIMUS Federal Services, Inc. has determined the request for **one (1) transforaminal epidural injection on the left at L5 and S1 is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **eight (8) chiropractic sessions for the neck and back is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 7/21/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/13/2013. 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 **one (1) transforaminal epidural injection on the left at L5 and S1 is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **eight (8) chiropractic sessions for the neck and back 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 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 is a 57-year-old female who suffered an industrial injury in 10/2008. The patient reportedly walked outside to help a customer pump gas when she stepped in a hole and fell forward, injuring her neck and low back. She reported having immediate pain and rated it an 8/10 on the pain scale. She states she has been under the care of Dr. [redacted] for her spine complaints. She has had an epidural steroid injection in 2009 with 80% relief for 6 to 8 months. She states the injection allowed her to increase her activities of daily living. In addition, the patient states she has completed chiropractic/physiotherapy as well as physical therapy and acupuncture all with moderate relief. In addition, she completes a home exercise program and stretching routine as tolerated. Documentation submitted for review from 06/18/2013 indicates the patient rated her pain at that time as a 6/10 on the pain scale. She states her low back pain was stabbing, aching, and throbbing with bilateral radicular symptoms, left greater than right traveling down the back of her legs to her calves, and to the bottom and top of her feet. The patient reports that she is taking Advil as needed. Physical examination findings include cervical, thoracic, and lumbar spine motions decreased in all planes. Upper and lower extremity sensations are intact, deltoids, biceps, and internal/external rotator/wrist extensor/flexors 4+/5 strength bilaterally, tibialis anterior and extensor hallucis longus/inversion/eversion and plantar flexors are 4+/5 bilaterally. An MRI of the lumbar spine dated 05/31/2013 revealed degenerative disc disease and facet arthropathy with levoscoliosis and grade I anterolisthesis at L2-3 through L4-5 with retrolisthesis L5-S1. Canal stenosis includes L3-4, L4-5, mild canal stenosis. Neural foraminal narrowing includes L2-3 mild to moderate bilaterally; L3-4 moderate right

moderate to severe left. L4-5 mild to moderate right and L5-S1 severe left neural foraminal narrowing.

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

1) **Regarding the request for one (1) transforaminal epidural injection on the left at L5 and S1 :**

   Section of the Medical Treatment Utilization Schedule 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), Epidural Steroid Injection (ESI), pp. 45-46, which is a part of MTUS.

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Epidural steroid injections (ESIs), pgs. 45-46, which are part of the MTUS.

   Rationale for the Decision:
   Chronic Pain Medical Treatment Guidelines indicate that epidural steroid injections are an option for treatment of radicular pain. Furthermore, current recommendations suggest a second epidural injection if partial success is produced with the first injection. According to the records presented for review, the employee does have subjective complaints of radiculopathy. However, even if the employee does have some decrease in range of motion of her lumbar spine, the physician indicates that the upper extremity and lower extremity sensation is intact without any objective documentation to indicate radiculopathy. Kemp's test is normal bilaterally. In addition, straight leg raise test is normal bilaterally. Furthermore, records do indicate that the employee has a history of epidural steroid injection in 2009. However, there are no documented records including VAS scores or objective documention of functional gains in regards to previous epidural steroid injection to indicate a successful outcome in regards to the criteria for repeat injection. **The request for one (1) transforaminal epidural injection on the left at L5 and S1 is not medically necessary and appropriate.**

2) **Regarding the request for eight (8) chiropractic sessions for the neck and back :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Manual Therapy, pp.58-59, which is a part of MTUS.
The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy, pgs. 58-59, which are part of the MTUS.

Rationale for the Decision:
Chronic Pain Medical Treatment Guidelines recommend manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement to facilitate progression in the employee's therapeutic exercise program and return to productive activities. In the treatment of low back, the recommendations are a trial of 6 visits over 2 weeks with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. Records provided for review indicate the employee has completed a total of 18 chiropractic/manual therapy visits at this time. While the employee still displays some complaints of low back pain with radicular symptoms to the lower extremities, the documentation submitted for review fails to support the request for an additional 8 chiropractic sessions as this would then exceed the recommended guidelines. Furthermore, there is a lack of documentation of any exceptional factors for the employee to continue with chiropractic sessions outside of the guidelines at this time. **The request for eight (8) chiropractic sessions for the neck and back**

**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

/sce

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.