

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
P.O. Box 138009  
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(855) 865-8873 Fax: (916) 605-4270



**Notice of Independent Medical Review Determination**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested C-7, T-1 Cervical Epidural Injections **are not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/30/2013 disputing the Utilization Review Denial dated 5/13/2013. A Notice of Assignment and Request for Information was provided to the above parties on 5/31/2013. 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 requested C-7, T-1 Cervical Epidural Injections **are 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 Internal Medicine, 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 May 13, 2013

#### **“History of Condition:**

Patient is a 62 year old male Director of Operations with a date of injury of 2/15/2013. The patient was injured as a passenger in a motor vehicle accident. The diagnosis is Axial neck pain, Myofascial pain, Cervical spondylosis. Cervical disc disease. Treatment to date: Chiropractic Therapy x 6 visits with minimal benefit; X-rays on 02/16/13 of the cervical spine noted degenerative change in the cervical region. No acute osseous injury noted; Vicodin (not currently taking); Ibuprofen. [REDACTED] DO report dated 04/30/13 noted the patient has moderately severe posterior neck pain without radiation. He continues to play golf weekly without impairment. Current medications included Benicar, Amlodipine, Lipitor. Past medical history positive for hypertension and hypercholesterolemia. Physical exam noted neck full range of motion with pain felt on rotation and extension. Mild diffuse posterior tenderness to palpation. Upper extremity muscle strength testing, reflexes and sensation intact. Plan notes the patient is suffering from axial neck pain and whiplash.

He has failed conservative treatment.

There is a noted request for physical therapy awaiting clarification of Frequency and Duration.”

**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 (received 5/30/13)
- Utilization Review Determination from [REDACTED] (dated 5/13/13)
- Correspondence from [REDACTED] (dated 3/15/13 – 5/20/13)
- Medical Records from [REDACTED] (dated 5/13/13/- 2/16/13)
- Medical Treatment Utilization Schedule (MTUS), Section 9792.24.2, Chronic Pain Guidelines (2009), pg 46, Epidural Injections

**1) Regarding the request for C-7, T-1 Cervical Epidural Injections:**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 (May, 2009), Part 2, Pain Interventions and Treatments, pg 46, of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured as a passenger in a motor vehicle accident on 2/15/13. Diagnosis was axial neck pain, myofascial pain, cervical spondylosis, and cervical disc disease. Treatment included six chiropractic treatments and analgesics. X-rays performed on 2/16/13 showed degenerative change in the cervical region. An examination on 4/30/13 revealed the employee was experiencing moderate/severe posterior neck pain without radiation. There was mild diffuse tenderness, and pain on rotation and extension with full range of neck motion. The report indicated the employee suffered from axial neck pain and whiplash, but continued to play golf on a weekly basis without impairment. A request for physical therapy was noted. The request did not state frequency and duration, and there was no indication that the employee attended any physical therapy sessions. C-7, T-1 Epidural Injections were requested.

Upon review of the medical records the employee sustained a whiplash injury with local and focal discomfort in the lower C-spine area. MTUS guidelines recommend "epidural steroid injections (ESIs) as an option for treatment of radicular pain (defined as pain in the dermatomal distribution with corroborative findings of radiculopathy)." There were no subjective or objective findings along the dermatomal distribution of C7-T1 that would suggest neurological deficits.

Six chiropractic visits were completed, which resulted in minimal benefit. MTUS guidelines state ESIs are recommended after an initial trial of conservative treatment including physical methods, NSAIDs, exercises and muscle relaxant. There is no evidence that physical therapy sessions have been undertaken in addition to the six chiropractic treatments, and the employee continued to play golf on a weekly basis without any peripheral symptoms. Therefore, the requested C-7, T-1 Epidural Injections **are 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.