

**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 Injection(s), Anesthetic Agent and/or Steroid **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/20/2013 disputing the Utilization Review Denial dated 5/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/20/2013. 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 Injection(s), Anesthetic Agent and/or Steroid **is medically necessary and appropriate.**

### **Medical Qualifications of the Professional Reviewer:**

The independent Doctor of Osteopathy who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, 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 professional 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 31, 2013.

“The patient is a 33-year-old male who sustained an industrial injury to his back and left hip in on 01/28/13. MRI of the lumbar spine without contrast performed on 03/18/13 revealed a 4 mm central protrusion at L5-S I and mild central spinal stenosis at L4-L5. In the treating physician report by Dr. [REDACTED] dated 04/26/13, on physical examination of the back and lower extremities, there was significant left leg limp, toe and heel walking were intact, range of motion was approximately 25% of normal in all planes, neurologic exam of the lower extremities showed no motor weakness, however decreased sensation in the left leg, reflexes were 2+ and equal at the knees and ankles, straight leg raising was painful at 60 degrees on the left, negative on the right, palpation of the lumbar spine and para spinal musculature revealed no localized tenderness or spasm, and internal and external rotation of the left hip remain highly painful. EMG/NCV perf01med on 05/16/13 revealed the following: 1) no electrophysiological evidence of entrapment neuropathy on the peroneal and tibial nerves; 2) no electrophysiological evidence to support motor radiculopathy in the lower extremities; and 3) no electrophysiological evidence to support distal peripheral neuropathy in the lower extremities. In the supplemental report by PA [REDACTED] dated 05/17/13, the patient was noted to remain highly symptomatic with left leg symptoms and numbness in the left foot. The patient was noted to be a candidate for an epidural steroid injection at LS-SI. The request is for ESI left L5-SI lumbar spine.”

### **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 dated 6/20/2013
- UR determination provided by [REDACTED] dated 5/31/2013
- Medical Records from 1/28/2013 through 5/22/2013
- American College of Occupational & Environmental Medicine (ACOEM) guidelines, 2<sup>nd</sup> Edition, 2004, Low Back Complaints, Epidural Steroid Injections, page 309
- California Chronic Pain Medical Treatment Guidelines (2009), Epidural Steroid Injections, page 36

**1) Regarding the request for Injection(s), Anesthetic Agent and/or Steroid:**

Medical Treatment Guideline(s) Relied Upon by the Professional Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the California Chronic Pain Medical Treatment Guidelines, 2009, ESI Treatments, page 36, 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. The Expert Reviewer additionally used the American College of Occupational and Environmental Medicine (ACOEM) guidelines, 2<sup>nd</sup> Edition, 2004, Low Back Complaints, Epidural Steroid Injections, page 307-310, of the MTUS.

Rationale for the Decision:

The employee sustained an injury to his back and left hip on 1/28/2013. An MRI without contrast was performed on 3/18/2013 and revealed a 4 mm central protrusion at L5-S1 and mild central spinal stenosis at L4-L5. The providers report dated 4/26/2013, revealed significant left leg limp and range of motion was approximately 25% of normal in all planes. There was pain on straight leg raising on the left, and pain with internal and external rotation of the hip. Neurological exam of the lower extremities revealed no motor weakness. An EMG/NCV performed on 5/16/2013 was essentially normal. A supplemental report dated 5/17/2013 noted that the patient remained highly symptomatic with left leg symptoms and numbness in the left foot. The request was made for Epidural Steroid Injections (ESI) at left L5-S1.

The ACOEM guidelines, 2004, 2<sup>nd</sup> Edition, Low Back Complaints of the MTUS state that epidural steroid injections are not recommended without radiculopathy. An EMG/NCV was conducted on 5/16/2013 and was negative for radiculopathy, however an MRI on 3/18/2013 revealed a 4 mm central protrusion at L5-S1 and mild central spinal stenosis at L4-L5. ACOEM guidelines do allow for ESI's as an option for radicular pain due to a herniated disc. The employee was given nine physical therapy sessions and approximately four months after the injury was still symptomatic. Conservative treatment has been attempted and has not resulted in improvement. The requested Injection(s), Anesthetic Agent and/or Steroid 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;

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

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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.