

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/6/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/3/2013
Date of Injury:	7/30/2002
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0010309

- 1) MAXIMUS Federal Services, Inc. has determined the request for **1 therapeutic disc injection with cortisone is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 8/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/17/2013. 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 therapeutic disc injection with cortisone** 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 Anesthesiology and Pain Management, 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 37-year-old who related having suffered from back and knee pain. Utilization review was performed on 8/3/13. A progress report dated 7/9/13 by Dr. [REDACTED] is the most recent record cited by the utilization review (UR) physician. Dr. [REDACTED] (psychiatry) has treated the injured worker with medication for psychiatric diagnoses. Dr. [REDACTED] (orthopedic surgery) has implemented conservative care treatments including medication and other modalities. The injured worker continues to suffer with back pain to date despite multiple treatments. Of note, she has been diagnosed with degenerative disc disease, arachnoiditis, epidural fibrosis, and has had 3 back surgeries (including a disc replacement at L5/S1 and/or a SynFix cage) and spinal cord stimulation. One intradiscal injection of cortisone has been recommended.

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 1 therapeutic disc injection with cortisone:

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

The Claims Administrator did not cite any evidence based criteria for its decision.

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 Simmons, J., et al., "Intradiscal steroids. A prospective double-blind clinical trial.", *Spine (Phila Pa 1976)*, 1992 Jun;17(6 Suppl):S172-5 and on Khot, A., et al., "The use of intradiscal steroid therapy for lumbar spinal discogenic pain: A randomized controlled trial.", *Spine (Phila Pa 1976)*, 2004 Apr 15;29(8):833-6; discussion 837.

Rationale for the Decision:

MTUS is silent on the requested treatment/service. Considering the lack of clinical documentation, and the evidence reviewed and cited above which demonstrates no benefit when evaluated in high-quality peer-reviewed clinical trials, medical necessity cannot be affirmed at this time. The submitted medical records do not support the requested services in this clinical setting. **The requested 1 therapeutic disc injection with cortisone 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/srb

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.