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Independent Medical Review
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MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/30/2013

IMR Case Number:	CM13-0010458	**Date of Injury:**	08/01/2008
Claims Number:	[redacted]	**UR Denial Date:**	07/23/2013
Priority:	STANDARD	**Application Received:**	08/14/2013
Employee Name:	[redacted]		
Provider Name:	[redacted] M.D.		
Treatment(s) in Dispute Listed on IMR Application:			
7/16/13: LEFT S1 NEUROFOREMEN EPIDURAL STEROID INJECTION WITH FLUOROSCOPY			

DEAR [redacted]

MAXIMUS Federal Services has completed the Independent Medical Review ("IMR") of the above workers' compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. This means we decided that all of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [redacted]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 55 year old male with a date of injury on 8/1/08. The patient's diagnoses include lumbago, left lower extremity, and L5/S1 radiculitis. The progress report dated 1/23/13 by Dr. [redacted] noted that the patient was with chronic low back pain and radiculitis in the left side. Exam findings showed a positive straight leg raise on the left to 60 degrees; decreased left Achilles reflex compared to right; slight weakness in the left hamstring and ankle dorsiplantar flexors; there is a decrease in sensation in the left S1 distribution with respect to pinprick, light touch and temperature. There are approximately 4-mm disc bulges at L4-L5 and L5-S1 levels from lumbar MRI dated 2/4/10. An electromyographic (EMG) study dated 8/12/08 showed a left S1 radiculopathy. It was noted that the patient had received some unknown type of pain procedure in 2010 by Dr. [redacted] that helped with his back pain for approximately three weeks. The progress report dated 5/1/13 noted that the patient's lumbar spine pain was progressively getting worse. The patient was doing home stretches twice a day. Physical therapy was being denied. The patient's exam findings were about the same with the addition of difficulty with toe ambulation and the patient needed a cane to ambulate. A repeat lumbar MRI was requested. The progress report dated 6/14/13 noted that the lumbar MRI appeal was denied again. The patient felt that his condition was worsening with more difficulty standing up in the morning. Exam findings were about the same. A request was made for a left S1 neuroforamen ESI.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. A left S1 neuroforaminal epidural steroid injection (ESI) with fluoroscopy is medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 46-47, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS guidelines indicate that ESI's are recommended in cases when radiculopathy has been documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and the patient has been initially unresponsive to conservative treatment. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. It is unclear from the records provided for review what procedure the employee had in 2010 and it does not appear that the employee has had any other procedures since; therefore, the requested ESI would be a reasonable option at this time. **The request for the neuroforaminal ESI is medically necessary and appropriate.**

/dso

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[redacted]

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