

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/27/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/29/2013  
Date of Injury: 3/12/2011  
IMR Application Received: 8/14/2013  
MAXIMUS Case Number: CM13-0010925

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: PARTIAL OVERTURN. This means we decided that some (but not 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 Pain Management and Rehabilitation and is licensed to practice in California, Ohio and Pennsylvania. 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 underlying date of injury in this case is 03/12/2011. The patient's diagnosis include brachial neuritis, cervical disc degeneration, cervical facet syndrome, thoracic spine pain, multilevel lumbar disc displacement, multilevel lumbar stenosis, lumbar facet syndrome, lumbosacral radiculitis, dysthymic disorder, and insomnia.

MRI imaging of the lumbar spine on 12/04/2012 demonstrated a bulge at L3-L4 with bilateral neural foraminal narrowing and also bulges at other levels although no specific nerve root impression. The patient has been noted to report ongoing low back pain with limited range of motion. This complex injury with a prior injury to the neck and low back and with the current injury occurring when this claimant attempted to catch a patient who fainted. A prior physician review noted that the patient's physical exam findings were not focal and the claimant had radiating pain. Therefore, the criteria for facet injections were not met. An internal medicine specialist clearance was felt to be not medically necessary since the underlying procedures were not recommended. A cervical pillow was recommended as not indicated given that there was no documentation that this would be used in conjunction with exercise. The prior review noted that there was no documentation that the patient had received functional benefit from chiropractic which had been previously provided, and there was no objective functional improvement noted from past acupuncture.

### IMR DECISION(S) AND RATIONALE(S)

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

- 1. Acupuncture for the neck, mid back, and lower back (frequency/duration not specified) is not medically necessary and appropriate.**

The Claims Administrator based its decision on Chapter 4.5 Divisions of Workers' Compensation, and Acupuncture Medical Treatment Guidelines, and Chronic Pain Medical Treatment Guidelines which is part of the MTUS.

The Physician Reviewer based his/her decision on the Acupuncture Medical Treatment Guidelines, Section 24.1, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The California Medical Treatment Utilization Schedule, Acupuncture Medical Treatment Guidelines, Section 24.1, states, "Acupuncture treatments may be extended if functional improvement is documented as defined in Section 92.20." The medical records do not document such functional improvement from past acupuncture. The guidelines have not been met.

**2. Lumbar epidural steroid injection at L3-L4, L4-L5 and the L5-S1 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM, Occupational Medicine Practices Guidelines, 2<sup>nd</sup> Edition, Chapter December, page 300, which is part of the MTUS. Also, Chronic Pain Medical Treatment Guidelines, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section Epidural Injection and page 46, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Medical Treatment Utilization Schedule, Chronic Pain Medical Treatment Guidelines Section Epidural Injection, page 46, states, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." The employee's symptoms in this case are nonfocal, as evidence among other items by the request for epidural injection at multiple levels. The employee does not meet the criteria for focal radiculopathy or lumbar epidural injection.

**3. Lumbar facet joint block at the medial branch at levels L3-L4, L4-L5 and L5-S1 bilaterally. If there is successful axial pain relief of greater than 70% for up to four hours, then we plan to proceed with a rhizotomy at the levels that meet this criteria is not medically necessary and appropriate.**

The Claims Administrator based its decision on the (ODG) Official Disability Guidelines, which is not part of the MTUS and Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Treatment of Workers' Compensation, Low Back, Facet Joint Diagnostic Injections, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Facet injections criteria are not specifically discussed in the Medical Treatment Utilization Schedule but are discussed in detail in the Official Disability Guidelines/Treatment of Workers' Compensation/Low Back under facet joint diagnostic injections. This guideline states, "clinical presentation may be consistent with facet joint pain, signs, and symptoms...limited to patients with low back pain that is nonradicular and at no more than 2 levels bilaterally." The medical records in this case describe diffuse pain at more than 2 levels which is radicular in nature. The employee does not meet the criteria consistent with facet joint pain, signs, and symptoms.

**4. Clearance from an Internal medicine specialist is not medically necessary and appropriate.**

The Claims Administrator based its decision on the (ODG) Official Disability Guidelines, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section Epidural Injection and page 46, which is part of the MTUS. Official Disability Guidelines (ODG), Treatment of Workers' Compensation, Low Back, Facet Joint Diagnostic Injections, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

This clearance had been requested prior to an epidural steroid injection and/or facet injection. Since those procedures have been noncertified, it follows that this request itself should be noncertified.

**5. Heat unit is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines and CA MTUS, which is part of the MTUS and additionally, (ODG) Official Disability Guidelines .

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 3 Treatment, page 48, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines, Chapter 3, Treatment, page 48, states, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise." The guidelines therefore support short-term use of low-tech heat or cold devices but do not support the purchase of such a device, particularly in the chronic phase.

**6. Cold unit is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS, and additionally, (ODG) Official Disability Guidelines, which is not part of MTUS.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 3 Treatment, page 48, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines, Chapter 3, Treatment, page 48, states, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise." The guidelines therefore support short-term use of low-tech heat or cold devices but do not support the purchase of such a device, particularly in the chronic phase.

#### **7. Cervical pillow is medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS, and additionally, (ODG) Official Disability Guidelines, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG)/Treatment of Workers' Compensation/Neck, which is not part of the MTUS. Also, on Other Medical Treatment Guideline or Medical Evidence: Medical Treatment Utilization Schedule Section on Physical Medicine, page 99, which is part of the MTUS.

The Physician Reviewer's decision rationale:

This equipment is not specifically discussed in the Medical Treatment Utilization Schedule. However, the Medical Treatment Utilization Schedule Section on Physical Medicine, page 99, states, "Allow for fading of treatment frequency plus active self-directed home Physical medicine." Additionally, the Official Disability Guidelines/Treatment of Workers' Compensation/Neck states regarding a cervical pillow, "Recommend use of a support pillow while sleeping in conjunction with daily exercise." This employee has been trained in a home exercise program for neck pain. The guidelines do support the use of a cervical pillow as part of this treatment. A prior reviewer noted that it is not clear that this was requested in conjunction with exercise, although the employee has received extensive physical therapy including instruction in a home exercise program. The guidelines would support this request.

#### **8. Chiropractic treatment for the neck, mid back and lower back (frequency/duration not specified) is not medically necessary and appropriate.**

The Claims Administrator based its decision on the (ODG) Official Disability Guidelines, which is not part of the MTUS and Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation, page 58, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Medical Treatment Utilization Schedule, Section on Manual Therapy and Manipulation, page 58, states, "Elective/maintenance care—not medically necessary." This employee has received extensive past treatment. The guidelines and the medical records do not provide a rationale for additional supervised chiropractic treatment at this time.

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.

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