

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/9/2013  
Date of Injury: 5/15/2012  
IMR Application Received: 8/19/2013  
MAXIMUS Case Number: CM13-0013846

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: UPHOLD. This means we decided that none 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 Anesthesiologist, has a subspecialty in Pain 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 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 51-year-old male who reported an injury on 05/15/2012. The current diagnoses include chronic sprain of the right wrist, lumbar spondylosis, lumbar disc protrusion and mild right lumbar radiculopathy. The patient was most recently evaluated on 09/11/2013 by Dr. [REDACTED]. Physical examination revealed slight tenderness of the right olecranon, tenderness diffusely over the right wrist, tenderness in the right lower lumbar paraspinal musculature, moderate guarding with palpable spasm, restricted straight leg raise on the right, hypoactive knee and ankle reflexes and hyperesthesia along the lateral aspect of the right thigh and calf. It was noted that the patient underwent a course of chiropractic care and physical therapy without improvement. Treatment recommendations at this time included an updated MRI of the lumbar spine, an updated electrodiagnostic study of the back and right lower extremity and a possible epidural steroid injection.

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

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

**1. Right Transforaminal Epidural Steroid Injection (ESI), at L4-5 and L5-S1 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS Chronic Pain Medical Treatment Guidelines, page 46 and American College of Occupational Environmental Medicine which is part of the MTUS. In addition The Official Disability Guidelines, Low Back, Hip and Pelvis, which is not part of the MTUS.

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

The Physician Reviewer's decision rationale:

The California MTUS Guidelines state, epidural steroid injections are recommended as an option for the treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Patients should prove initially unresponsive to conservative treatment. Repeat blocks are based on continued objective documented pain and functional improvement, including at least 50% pain relief with an associated reduction of medication use for 6 to 8 weeks. As per the clinical notes submitted, the employee underwent a lumbar epidural steroid injection (ESI), on the right at L4-5 and L5-S1 on 05/21/2013. There is no documentation of functional improvement or a decrease in medication use following the initial ESI. Additionally, the employee's Electromyogram (EMG), study on 10/12/2012 indicated no evidence of radiculopathy. Without documentation of at least 50% pain relief with an associated reduction of medication use following the initial injection, the current request cannot be determined as medically appropriate. **The request for Right Transforaminal Epidural Steroid Injection (ESI), at L4-5 and L5-S1 is not medically necessary and appropriate.**

/bd

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.

[REDACTED]  
[REDACTED]  
[REDACTED]

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