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## Independent Medical Review Final Determination Letter

792

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

Dated: 12/27/2013

<b>IMR Case Number:</b>	CM13-0017723	<b>Date of Injury:</b>	03/28/2011
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/20/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/28/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED]		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
64483, 64483			

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 Physical Medicine and 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]
- [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:

53 y.o. female with injury from 3/28/11 from a fall, suffers from chronic right shoulder, low back, right knee, right elbow, right ankle and wrist/hand pains. MRI of L-spine from 11/25/12 showed 3.8 left disc herniation, 3mm central protrusion at L5-S1. The patient underwent lumbar epidural shunt with injections bilaterally at L4 and L5 transforaminal approach on 7/18/13. Follow up note by Dr. [REDACTED] 7/29/13 notes that the patient only had 1 week pain relief and now worsening of pain. EMG was negative for radiculopathy from 2/6/13.

Dr. [REDACTED] note from 10/2/13 was reviewed and there is no discussion of ESI. The patient has persistent low back pain. The patient's other complaints are addressed. Progress report from 9/6/13 states that the patient has back pain moderate with significant limitations, condition is not showing improvement. Request is made for a repeat injection stating that a second injection is reasonable with a favorable response after 1-2 weeks of the first injection.

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

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

**1. Lumbar Epidural Steroid Injection at L3-4 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS Chronic Pain Medical Treatment Guidelines, page 46, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 46-47, which are part of the MTUS.

The Physician Reviewer's decision rationale:

This patient suffers from chronic low back and leg symptoms and it was quite reasonable to try an ESI. However, the ESI did not provide significantly lasting relief of the symptoms. MTUS requires 50% reduction of pain lasting at least 6 weeks before a second injection should be tried and in this patient, pain relief only lasted 1 week before pain returned. The treater believes that a second injection should be tried but unfortunately, MTUS does not support this. Careful reading of ODG guidelines do not support repeating injection within 1-2 weeks. Rather, repeat injection is recommended only after demonstration of reduction of pain and improvement of function. Recommendation is for denial.

## **2. Lumbar Epidural Steroid Injection at 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, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 46-47, which are part of the MTUS.

The Physician Reviewer's decision rationale:

There is a small disc at L5-S1 and the treater is requesting an ESI at this level. However, this patient already tried an ESI that only resulted in transient reduction of pain lasting 1 week. Furthermore, the treaters do not describe any S1 radicular symptoms or any examination findings that are consistent with S1 radiculopathy that would warrant trying an injection at this level. MTUS does not allow repeat injection unless 50% or more reduction of pain with functional improvement is achieved lasting at least 6 weeks. MTUS does not allow an ESI without documentation of radiculopathy. In this case, there is lack of documentation of radiculopathy that would corroborate the findings at L5-S1, namely small disc protrusion. Recommendation is for a denial.

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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[REDACTED]  
[REDACTED]