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**Notice of Independent Medical Review Determination**

Dated: 9/18/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/10/2013  
Date of Injury: 9/21/2012  
IMR Application Received: 7/18/2013  
MAXIMUS Case Number: CM13-0001867

- 1) MAXIMUS Federal Services, Inc. has determined the requested cervical epidural steroid injection at C6-7 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested lumbar epidural steroid injection at L4-5 **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 requested cervical epidural steroid injection at C6-7 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested lumbar epidural steroid injection at L4-5 **is 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 Occupational 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 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.

### Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 10, 2013:

“History of Condition: The question is: should the 1.) Cervical ESI at C6-7 2.) Lumbar ESI at L4-5 be authorized? History: [REDACTED] has a DOI of 09/21/12 and is noted to be a 43 y/o male. This patient has Lumbar spondylosis without myelopathy. MCM noted NARRATIVE: Injury/Mechanism of injury: This claim involves a 42 year old driver who has been with the insured since 5/1/07. The IW was involved in a motor vehicle accident on 9/21/12. The employee reports that the truck in front of him slammed on his brakes and he rear ended the truck. Employee was very dizzy because he hit his head on either the window or door. The day after this accident the EE had significant pain in his left shoulder and back. Treatment to date: 6•PT 9/2012-10/2012, MRI Cervical 10/17/13, EMG/NCS 11/1/12, 24 PT 10/2012-1/2013, MRI Lumbar 1/11/13, MRI Shoulder 1/11/13, EMG/NCS Lower extremities 1/10/13, 12 PT 2/2013- 4/2013, audiogram, MRI Brain. Guideline/protocol referenced: MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES. On 11/01/12 EMG/NCVs of upper extremities noted no radiculopathy. On 01/10/13 EMG/NCVs of lower extremities noted no radiculopathy. On 02/15/13 Dr. [REDACTED] noted EMG/NCVs were normal and lumbar spine noted two levels of disc bulge at L4-L5 and L5-S1 with left sided stenosis. Shoulder injection on that date with note of request for PT for left shoulder and lumbar spine. On 03/29/13 doctor noted MRI of cervical spine documented spondylosis with note of left sided C6-C7 neuroforaminal narrowing. On 05/02/13 AME evaluation. Diagnoses included chronic residuals of multiple strain/sprain injury. AME noted for future medical care that injections were possible in both cervical/umbar spine. On 05/13/13 doctor noted evaluation. Rear ending another truck was mechanism of injury.

Course of care summarized. Complaints included low back pain with left hip and left lower extremity radicular complaints. Also left shoulder pain with radiation into neck and down left upper extremity. Full ROM of neck noted with note of weakness in left hand with grip testing. Lumbar ROM decreased with intact sensation and motor testing. SLR positive on right leg. He noted MRI of cervical spine noted C6-C7 HNP to the left and also an HNP at L4-L5 in lumbar spine. Failure of care noted and request was submitted for both cervical and lumbar spine ESIs. This is now request for review.”

**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 for Independent Medical Review (dated 7/18/2013)
- Utilization Review from [REDACTED] (dated 7/10/2013)
- Medical Records from [REDACTED], MD (dated 9/21/12)
- Medical Records from [REDACTED] (dated 9/21/12-10/18/12)
- Medical Records from [REDACTED] (dated 10/17/12)
- Medical Records from [REDACTED] (dated 10/19/12-8/9/13)
- Medical Records from [REDACTED] (dated 1/10/13)
- Medical Records from [REDACTED], MD (dated 1/31/13-6/20/13)
- Medical Records from [REDACTED], MD (dated 3/20/13-4/25/13)
- Medical Records from [REDACTED], MD (dated 5/2/13-6/3/13)
- Medical Records from [REDACTED] (dated 5/13/13-5/17/13)
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for Cervical epidural steroid injection at C6-7:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009) pg. 49, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009) pg. 36, which is a part of MTUS, relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 9/21/2012 to the head, left shoulder, and back. Current diagnoses are lumbar spondylosis without myopathy, chronic residuals of multiple strain/sprain injury. Treatment to date has included diagnostic studies, medication management, and physical therapy. The request is for cervical epidural injection at C6-7.

The MTUS Chronic Pain Medical Treatment Guidelines state epidural steroid injections are indicated in the treatment of radiculopathy. The medical records provided for review indicate that there is clinical evidence of radiculopathy and

radiographic corroboration. Additionally, MTUS Chronic Pain Medical Treatment Guidelines support the usage of epidural steroid injection treatment for diagnostic purposes. There is no indication of any prior epidural steroid injections. The request for Cervical Epidural Injection at C6-7 is medically necessary and appropriate.

**2) Regarding the request for Lumbar epidural steroid injection at L4-5:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009) pg. 49, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009) pg. 36, which is a part of MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 9/21/2012 to the head, left shoulder and back. Current diagnoses are lumbar spondylosis of the lumbar spine without myopathy, chronic residuals of multiple strain/sprain injury. Treatment to date has included diagnostic studies, medication management, and physical therapy. The request is for Lumbar Epidural Steroid Injection at L4-5.

The MTUS Chronic Pain Medical Guidelines indicates lumbar epidural steroid injection at L4-5 is indicated in the treatment of radiculopathy. The medical records provided for review indicate that the employee has ongoing radicular complaints, positive straight leg raising, and some radiographic corroboration of radiculopathy as noted on MRI images which would meet guideline criteria for an epidural steroid injection. The request for lumbar epidural steroid injection at L4-5 is 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;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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Oakland, CA 94612

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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.