

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/9/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/10/2013
Date of Injury:	10/12/2012
IMR Application Received:	7/17/2013
MAXIMUS Case Number:	CM13-0001879

- 1) MAXIMUS Federal Services, Inc. has determined the request for an outpatient lumbar epidural steroid injection, second and third at L4/5 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Naprosyn 375mg **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/17/2013 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 request for an outpatient lumbar epidural steroid injection, second and third at L4/5 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Naprosyn 375mg **is not 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 Physical Medicine & Rehabilitation, 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:

It is the opinion of the reviewing physician that, "This claimant was injured in October 2012 in California. There is lumbago. It is noted that on June 7, the ESI requests were denied. There is an 11 mm disc herniation, with right lower extremity radiculopathy. There is decreased right L5 sensation, and EMG confirms a right active L5 denervation. The previous injection request was not certified, because the response to the first one was not provided. Again, in the doctor's note from 6-10-13, there is no documentation of the outcome of the first one.

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 07/17/2013)
- Utilization Review by [REDACTED] (dated 07/10/2013)
- Medical records from Claims Administrator [REDACTED] (dated 08/06/2013)
- Medical records from Employee/Employee Representative
- Medical Treatment Utilization Schedule

1) Regarding the request for an outpatient lumbar epidural steroid injection, second and third 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), which is part of the California Medical Treatment Utilization Schedule (MTUS), but did not cite a specific section. The Claims Administrator also cited the Official Disability Guidelines (ODG), which is a medical treatment guideline that is not part of the MTUS, but did not cite a specific section. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), page 46, which is part of the MTUS.

Rationale for the Decision:

The employee was injured on 10/12/2012 and has experienced ongoing low back pain with radiation of pain down his right lower extremity. Treatment has included imaging, electrodiagnostic testing, and a prior epidural steroid injection on 1/25/2013, with only 3 days of relief following the injection. A request was submitted for an outpatient lumbar epidural steroid injection, second and third at L4/5.

The MTUS Chronic Pain Medical Treatment Guidelines state 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 6 to 8 weeks. The records submitted and reviewed document the employee had pain relief for 3 days following the previous epidural steroid injection performed on 1/25/2013. The request for additional epidural steroid injections does not meet the criteria for repeat injection. The request for an outpatient lumbar epidural steroid injection, second and third at L4/5 **is not medically necessary and appropriate.**

2) Regarding the request for Naprosyn 375mg:

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Non-Steroidal Anti-Inflammatory Drugs section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 67-68, which are part of the MTUS.

Rationale for the Decision:

The employee was injured on 10/12/2012 and has experienced ongoing low back pain with radiation of pain down his right lower extremity. Treatment has included imaging, electrodiagnostic testing, and a prior epidural steroid injection on 1/25/2013, with only 3 days of relief following the injection. A request was submitted for Naprosyn 375mg.

The MTUS Chronic Pain Guidelines recommended naproxen as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. Naproxen is also recommended as an option for short-term symptomatic relief for treatment of chronic pain but there is no indication for use for treatment of neuropathic pain. The employee's records document that he has been taking naproxen on a routine, long-term basis. Continued use does not meet the guideline recommendations. The request for Naprosyn 375mg **is not 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
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sab

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.