
Notice of Independent Medical Review Determination

Dated: 10/10/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/10/2013
Date of Injury: 10/3/2010
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003348

- 1) MAXIMUS Federal Services, Inc. has determined the request for one (1) cervical epidural steroid injection (ESI) **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for one (1) spinal cord stimulator system (CSC) **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 one (1) cervical epidural steroid injection (ESI) **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for one (1) spinal cord stimulator system (CSC) **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 and 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:

“The patient is a 47 year old male with a date of injury of 10/3/2010. The provider has submitted a prospective request for 1 cervical epidural steroid injection and 1 spinal cord stimulator system. A review of the submitted documents indicates the patient was being treated for neck pain. Per an evaluation on 6/4/13 by Dr. ■■■, relevant objective findings included moderate cervical paraspinal and bilateral upper extremity spasm and tenderness, moderate cervical vertebral tenderness, and decreased cervical spine range of motion. Prior treatment has included rehab therapies, chiropractic care, a home exercise program, medication, and an anterior cervical discectomy and fusion at C5-C7.”

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 (received 7/25/2013)
- Utilization Review Determination from Claims Administrator (dated 7/10/2013)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for one (1) cervical epidural steroid injection (ESI) :

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), Epidural steroid injections (ESIs), pg. 46, 47 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 guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on October 3, 2010 resulting in neck pain. According to the medical records provided for review, findings included moderate cervical paraspinal and bilateral upper extremity spasm and tenderness, moderate cervical vertebral tenderness, and decreased cervical spine range of motion. Treatments have included rehab therapies, chiropractic care, a home exercise program, medication, and an anterior cervical discectomy and fusion at C5-C7. The request is for one (1) cervical epidural steroid injection (ESI).

MTUS Chronic Pain Medical Treatment Guidelines state that "the purpose of ESI is to reduce pain and inflammation, restoring range of motion, and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit." Per the medical records reviewed, the employee is status post 3 level discectomy and fusion from C5-T1. The employee continues to experience pain in the neck and the upper extremities. The treater feels that the employee has radiculopathy and would like to perform epidural steroid and/or diagnostic ESIs. However, the treater does not specify at what level the employee has radiculopathy. The employee has non-specific pain down the arms, as many individuals do following this type of surgery. There is no evidence that this employee has radiculopathy, although the employee does experience 'radicular' symptoms. Furthermore, the employee does not have radiographic evidence of a nerve root lesion such as disc herniation or stenosis. Diagnostic injections are indicated if there is confusion as to what level of lesion is causing the employee's radiculopathy; the MRI was fairly clean in the levels that were not operated on. The request for one (1) cervical epidural steroid injection (ESI) **is not medically necessary and appropriate.**

2) Regarding the request for one (1) spinal cord stimulator system (CSC) :

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), Spinal cord stimulators (SCS), pgs. 105-107, which is part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May, 2009) pg. 101, which is part of

the MTUS, and additionally referenced the Official Disability Guidelines (ODG) Spinal Cord Stimulator, a medical treatment guideline which is not part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on October 3, 2010 resulting in neck pain. According to the medical records provided for review, findings included moderate cervical paraspinal and bilateral upper extremity spasm and tenderness, moderate cervical vertebral tenderness, and decreased cervical spine range of motion. Treatments have included rehab therapies, chiropractic care, a home exercise program, medication, and an anterior cervical discectomy and fusion at C5-C7. The request is for one (1) spinal cord stimulator system (CSC).

MTUS Chronic Pain Medical Treatment Guidelines recommend a trial of spinal cord stimulation (SCS) and a psychological evaluation; the Official Disability Guidelines require the psychological evaluation. This employee has the indication for spinal cord stimulation, but has not had a proper work-up including psychological screening and a trial of SCS. The request for one (1) spinal cord stimulator system (CSC) **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

/slm

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