

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
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**Notice of Independent Medical Review Determination**

Dated: 10/28/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	11/1/2010
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003791

- 1) MAXIMUS Federal Services, Inc. has determined the request for for lumbar ESI L4-5 and L5-S1 **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 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. 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 lumbar ESI L4-5 and L5-S1 **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Orthopedic Surgery who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, 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 9, 2013:

“The patient is a 45 year old male who reported an injury on the 11/01/2010. He was exiting his big rig truck when he slipped and fell backwards landing on his lumbar spine per Dr. [REDACTED] in his note of 06/25/2013. Current medications Include Soma, Percocet, Neurontin and Ambien. There is no surgical history provided. Dr. [REDACTED] stated that the patient had EMG/ NCS on 10/21/2011. The impression was abnormal. Decreased amplitude of compound motor action potential on bilateral dig brevis muscle is secondary to anterior tarsal tunnel syndrome or atrophy of these muscles. DTR reduced 1+L4 bilateral. An MRI was done on 06/30/2011 of lumbar showed mild spondylitic degenerative changes, L4-5 mild annular type disc bulge and very mild lateral recess and foraminal narrowing, which shows sensory and mild motor digit arrocuated with L4-5 demotonal distribution. Previous reviewers note stated that the patient physical therapy and anti-inflammatories which did not improve his condition. EMG/NCS that was performed on 10/12/2012 diagnosed the patient positive for bilateral carpal tunnel syndrome. The patient complains of upper and lower back pain which is constant and rates at 9/10. Examination of his back reveals positive paravertebral mild spasms, tenderness to palpation, positive sacral compression. He has positive straight leg raise, positive Lasegue's test. However no MRI report, or EMG studies or information to support his physical therapy sessions was received. There was no examination to indicate any neurological deficits of weakness Given the reviewed information the request is noncertified.”

### **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 of Independent Medical Review
- Utilization Review Determination from Claim Administrator
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for lumbar ESI L4-5 and L5-S1 :**

##### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 46, part of the MTUS. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, page 46, Epidural Steroid Injections (ESIs), part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

##### Rationale for the Decision:

The employee injured the low back on 11/01/2010. The submitted and reviewed medical records indicate that the employee has had physical therapy, MRIs, EMG/NCV studies, and medications. The most recent medical report, dated 7/03/2013, indicates that the employee continues to have lumbosacral spine pain with radiculopathy/radiculitis with pain level rated 10/10. A request was submitted for epidural steroid injections.

The MTUS Chronic Pain guidelines indicate they epidural steroid injections are intended to reduce pain and inflammation and restore range of motion, thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The guideline criteria indicate radiculopathy should be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and there should be an initially unresponsive course of conservative treatment including exercises, physical methods, NSAIDs and muscle relaxants. Based on the documentation submitted, there is no indication of nerve root impingement at the L5-S1 level and no significant compromise of the exiting nerve roots at the L4-5 level. The physical examination conducted on 07/03/2013 does identify decreased sensation in an L4 dermatomal pattern bilaterally. The request for lumbar epidural steroid injection (ESI) at L4-5 and L5-S1 **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, 18<sup>th</sup> Floor  
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.