

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/30/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/18/2013
Date of Injury:	5/16/2005
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004101

- 1) MAXIMUS Federal Services, Inc. has determined the request for hot/cold therapy unit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for selective epidural catheterization of the right C6-T1 epidural interspace with infusion of anesthetic and steroid times two (2) **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/9/2013. 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 hot/cold therapy unit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for selective epidural catheterization of the right C6-T1 epidural interspace with infusion of anesthetic and steroid times two (2) **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.

Expert Reviewer Case Summary:

The patient has a date of injury of 5/16/2005. The claimant c/o of neck pain radiating to the bilateral upper extremities with numbness in the fingers. Examination showed tenderness and spasm in the neck. Spurlings in positive. ROM is limited. Sensory showed decreased along the right C6, C7 and C8 dermatomes. Muscle testing showed weakness in the C5-C7 myotomes. MRI showed central stenosis at C5/6 and C6/7 with disc protrusions. Claimant has failed conservative measures.

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 (received 7/29/13)
- Utilization Review Determination from [REDACTED] (dated 7/18/13)
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for hot/cold therapy unit:

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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 8, pages 173-174, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also based its decision on the Official Disability Guidelines (ODG), Neck & Upper Back Procedure Summary, which is a medical treatment guideline that is not part of the MTUS. The Expert Reviewer relied on ACOEM, 2nd Edition, (2004), Chapter 8, page 173-175, which is part of the MTUS.

Rationale for the Decision:

The ACOEM Guidelines state that heat/cold therapy is an optional therapy and only recommended for a few days as initial care at home. The employee has chronic pain with a date of injury in 2005. ACOEM states that there is no high grade scientific evidence to support the effectiveness of passive modality like heat/cold. **The request for hot/cold therapy unit is not medically necessary or appropriate.**

2) Regarding the request for selective epidural catheterization of the right C6-T1 epidural interspace with infusion of anesthetic and steroid times two (2):

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 (2009), which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 46, which is part of the MTUS.

Rationale for the Decision:

The California MTUS Chronic Pain Medical Treatment Guidelines state on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection. The employee fits the criteria for the epidural injection. However, per the guidelines, the second epidural is recommended when the first injection shows functional improvement and 50% reduction of symptoms. **The request for selective epidural catheterization of the right C6-T1 epidural interspace with infusion of anesthetic and steroid times two (2) is not medically necessary or 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/skf

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.