

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/20/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/17/2013
Date of Injury:	4/29/2009
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004883

- 1) MAXIMUS Federal Services, Inc. has determined the request for a **lumbar epidural injection** 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 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 a **lumbar epidural injection** 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:

There is a handwritten PR2 from Dr. [REDACTED] PA dated 7/12/13 that requests a LESI x1 for back pain and LE pain. The patient complains of pain in both shoulders and knees. Left knee had some improvement with orthovisc injections. SLR is reported as positive on the left, negative on right, but no description of any dermatomal distribution. There was a 2/20/13 AME from Dr. [REDACTED], noting complaints in the right shoulder, left knee, low back and left shoulder. 4/4 categories of Waddell's signs were present. The AME did not discuss ESI for future medical. The patient's pain drawing was provided, it was dated 2/20/13, it mentions left knee pain, grinding and locking, but does not show any radicular symptoms. The 9/14/12 left knee MRI showed patellofemoral osteoarthritis

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 [REDACTED]
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for a lumbar epidural injection:

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

The Claims Administrator based its decision on the California MTUS 2009: Section 9792.24.2 – Chronic Pain Medical Treatment Guidelines, page 46: Epidural Steroid Injections (ESIs), which is part of the MTUS.

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

Rationale for the Decision:

MTUS criteria for Epidural Steroid Injections (ESIs) require radiculopathy to be documented by physical examination and corroborated with imaging or electrodiagnostics. The medical records provided for review do not indicate there are any radicular findings on examination. The employee's left knee symptoms were from the patellofemoral arthritis from the knee and not from a radicular etiology. There do not appear to be any clinical findings suggestive of radiculopathy, and no imaging or electrodiagnostic findings to corroborate a diagnosis of radiculopathy. The request does not meet the MTUS criteria for ESI. **The request for lumbar epidural injection times 1 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th 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.