

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



---

**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/31/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/31/2013  
Date of Injury: 6/12/2008  
IMR Application Received: 7/31/2013  
MAXIMUS Case Number: CM13-0006070

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 6/12/2008. The primary treating diagnosis is a lumbar sprain. The initial diagnosis include L4-L5 facet generation, left-sided neuroforaminal stenosis at L5-S1, status post a superior labrum repair in 2008 at the left shoulder, cervical sprain with bulge at C4-C5, and sleep disorder, as well as psychological trauma. The treating physician notes indicate that the patient previously underwent an epidural injection in September of 2011 and had significant relief, and that he was a candidate for repeat injections given his symptoms and evidence of radiculopathy. On physical examination the patient was noted to have stiffness and spasm in the lumbar spine with evidence of a radiculopathy and positive straight leg raise.

### IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **1. Lumbar epidural injection, L5-S1 is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Epidural Injections, pg. 46, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Medical Treatment Guidelines indicate that radiculopathy must be documented on physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In 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 6-8 weeks. The medical records submitted for review at this time do not provide specificity regarding the benefits of past epidural injections consistent

with these guidelines. Additionally, the physical examination and diagnostic data is equivocal to support the presence of a specific focal radiculopathy. Therefore, the employee does not meet the criteria either for initial or repeat epidural injections. **The request for Lumbar epidural injection, L5-S1 is not medically necessary and appropriate.**

/fn

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.



CM13-0006070