

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/25/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	4/21/2011
IMR Application Received:	8/6/2013
MAXIMUS Case Number:	CM13-0007469

- 1) MAXIMUS Federal Services, Inc. has determined the request for **epidural steroid injection using fluoroscopy at bilateral L5- S1 level with Dr. [REDACTED]** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **motorized scooter for work** is not medically necessary and appropriate.

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/9/2013. 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 **epidural steroid injection using fluoroscopy at bilateral L5- S1 level with Dr. [REDACTED]** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **motorized scooter for work 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 sustained a work-related injury on 4/21/11. The patient reports chronic pain of T, L-spine, right knee chondromalacia, left knee arthritis. The 03/22/2010 MRI reveals diffuse disc bulges 3-4 mm at L3-4, right sided bulge 2-3 mm at L4-5, and a bulge at 3-4mm at L5-S1. Dr. [REDACTED] handwritten progress note dated 08/08/2013 indicates the patient complains of persistent left knee and low back pain. The patient has gained 60 lbs since injury.

Dr. [REDACTED] 06/27/2013 report indicates the patient has low back pain, (LBP) with left leg pain, and pain in both knees.

5/18/13, pain management consult, neck pain with bilateral arm pains, low back pain with left leg radiation. Self-report difficulties with self-care/hygiene, activities, ambulation and sleep. Medication tramadol only. Weight 220, 5'7". Motor and sensory exam normal for legs. SLR were negative bilaterally. Recommendation was for diagnostic transforaminal injections at L5-S1.

2/21/13, QME report, reference to L5-S1 lumbar ESI. This helped for few weeks but pain came back. Second ESI was approved but patient declined.

**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:



**1) Regarding the request for epidural steroid injection using fluoroscopy at bilateral L5- S1 level with Dr. [REDACTED]**

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, Epidural Steroid Injections (ESIs), page 46, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Epidural Steroid Injections (ESIs), and cited pages 46-47 as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee has a negative neurologic examination including motor and sensory. SLR was negative. While the employee has radicular symptoms, no radiculopathy has been documented via physical examination, MRI or EMG. The MRI showed bulging discs and foraminal stenosis that can cause radiculopathy, but again, no examination showing nerve root problem such as SLR or motor/sensory changes. Furthermore, review of the records show that the employee has had an ESI in the past with minimal results. A second injection was offered but the employee declined at the time. For repeat injections, MTUS requires 50% reduction of pain lasting 6-8 weeks. This was not the case with the first injection. **The request for epidural steroid injection using fluoroscopy at bilateral L5- S1 level with Dr. [REDACTED] is not medically necessary and appropriate.**

**2) Regarding the request for motorized scooter for work:**

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, Power mobility devices (PMDs), section 9792.24.2, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Power mobility devices, page 99, which is a part of the MTUS.

Rationale for the Decision:

While this employee suffers from chronic low back and knee pains with radicular symptoms and arthritic knee, the employee has normal examination of the lower extremities with no weakness or ambulation problems. What the employee experiences are subjective pains with subjective difficulties with ambulation.

MTUS does not support power mobility device if functional deficit can be sufficiently resolved by cane, walker, or with sufficient upper extremity strength.

**The request for a motorized scooter for work 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/ejf

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.