

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/29/2013
Date of Injury: 11/4/2003
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0007774

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 Pain Management, and is licensed to practice in Ohio and Texas. 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] Provider
- Medical Treatment Utilization Schedule (MTUS)

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 patient is a 32-year-old female who reported an injury on 11/04/2003. The mechanism of injury was not provided for review. The patient underwent L5-S1 decompression and fusion. The patient was also treated with chiropractic care, medication management, and epidural steroid injections. The patient has continued neck and low back complaints of pain rated at a 4/10 to 6/10. Physical findings included decreased sensation in the C5, C6, C7, and C8 dermatomes. Decreased sensation in the right L5 and L4 dermatomes was also noted. The patient had tenderness to palpation of the bilateral paraspinal musculature. The patient's diagnoses included complex regional pain syndrome in the right upper extremity, lumbar degenerative disc disease with radiculopathy, cervical degenerative disc disease, and dystonia of the upper limb related to complex regional pain syndrome. The patient's treatment plan included continued chiropractic care and transforaminal epidural steroid injection.

IMR DECISION(S) AND RATIONALE(S)

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

1. Additional chiropractic care - one (1) time a week for twelve (12) weeks for the back is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is a part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical treatment Guidelines, Manual therapy, pg. 58, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

A review of the records indicates that the employee does have continued back complaints that did respond well to prior chiropractic treatment. The employee had increased functional capabilities and a decrease in pain. The California Medical Treatment and Utilization Schedule recommends manual therapy for the low back up to 18 visits with evidence of objective functional improvement. The clinical documentation submitted for review provides evidence that the employee already received 12 visits of chiropractic care. As such, the requested 12 additional visits exceeds the 18 visit recommendation. There are no exceptional factors noted within the documentation to support the need to extend treatment beyond Guideline recommendations. Maintenance care with the use of manual therapy is not supported by the California Medical Treatment and Utilization Schedule. **The request for additional chiropractic care – one (1) time a week for twelve (12) weeks for the back is not medically necessary and appropriate.**

2. Transforaminal epidural steroid injection (ESI) at right L4, L5, and S1 roots is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg 46, which is a part of the MTUS.

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

The Physician Reviewer's decision rationale:

A review of the records indicates that the employee does have low back pain with radicular symptoms. The California Medical Treatment and Utilization Schedule does recommend epidural steroid injections for radiculopathy that is supported by an imaging study and objective clinical findings that have failed to respond to conservative treatments. The clinical documentation submitted for review does provide evidence that the employee has objective physical findings of radiculopathy to include disturbed sensation in the L4, L5, and S1 dermatomes. However, the clinical documentation submitted for this review did not include an MRI to corroborate these physical findings. Additionally, the clinical documentation submitted for review does provide evidence that the employee was responding favorably to conservative care to include chiropractic care and medications. Also, it is noted within the documentation that the employee previously received an epidural steroid injection. There was no documentation submitted for review that the employee received any pain resolution or functional benefit as a result of that prior epidural steroid injection. **The request for transforaminal epidural steroid injection (ESI) at right L4, L5, and S1 roots is not medically necessary and appropriate.**

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.

[REDACTED]

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