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Independent Medical Review
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MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/27/2013

Employee:	[redacted]
Claim Number:	[redacted]
Date of UR Decision:	7/26/2013
Date of Injury:	1/11/2013
IMR Application Received:	8/6/2013
MAXIMUS Case Number:	CM13-0007980

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 PM&R, and is licensed to practice in Pennsylvania. 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 01/11/2013. The record's diagnoses include cervical, thoracic, and lumbar sprains. This patient was initially injured when moving a roll of roofing paper with a forklift. Electrodiagnostic studies of the lower extremities were noted to be normal in the past. MRI of the cervical spine demonstrated multilevel cervical degenerative disc disease. An electrodiagnostic study of the upper extremities demonstrated mild right carpal tunnel syndrome with no evidence of cervical radiculopathy. Prior physician reviews of 07/25/2013 and 07/18/2013 noted that information was missing including incomplete cervical MRI information. Therefore, that reviewer recommended non-certification based on the absence of a response for additional information but not based on medical necessity.

An appeal letter currently from the treating physician of 09/13/2013 notes that the patient has been diagnosed with herniated nucleus pulposus of the cervical spine and herniated nucleus pulposus of the lumbar spine and a herniated nucleus pulposus of the thoracic spine as well as cervical radiculopathy and right shoulder arthralgia. The treating physician provided medical records including a report from the treating physician of 06/01/2013 and an MRI of the cervical spine report of 04/15/2013.

Treating physician report of 06/10/2013 reviews the results of an MRI of the cervical spine of 04/15/2013 which described degenerative disc disease as well as reversal of the cervical lordosis and also canal stenosis which was mild at C3-C4 and mild at C4-5 and C5-6 and also mild stenosis at C6-C7 without evidence of neural foraminal narrowing. An MRI of the thoracic spine additionally demonstrated multiple protrusions. On physical examination, the patient had decreased sensation at right L4-S1 dermatomes. The patient was hyperreflexic in the bilateral upper and lower extremities. The patient had decreased range of motion at the cervical, thoracic, and lumbar spines in all directions. The patient had decreased sensation in the right C5 and C8 dermatomes. Treatment was recommended to include interlaminar epidural injection with catheter replacement at C7-T1 in order to target the C4-5 and C5-6 levels.

IMR DECISION(S) AND RATIONALE(S)

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

1. Interlaminar epidural steroid injection with catheter replacement C7-T1 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 on Epidural Injections, which is part of the MTUS.

The Physician Reviewer's decision rationale:
The Chronic Pain Medical Treatment Guidelines Section on Epidural Injections states, "There is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain… Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In this case, additional information has been provided subsequent to a prior physician non-certification. I note that the treatment guidelines provide only equivocal support for cervical epidural injections in general, contingent upon specific documentation of indications for a particular patient. This patient has multifocal symptoms, multifocal physical exam findings, and multifocal diagnostic findings involving the cervical and lumbar spine. The medical records and guidelines do not support the probability of focal cervical radiculopathy at this time. Overall the records and diagnostic data do not corroborate the presence of a cervical radiculopathy as recommended by the treatment guidelines. Overall this treatment is not medically necessary.

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.

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