
Notice of Independent Medical Review Determination

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/17/2013

3/16/1995

8/13/2013

CM13-0010688

- 1) MAXIMUS Federal Services, Inc. has determined the request for **1 IM injection of Toradol 60 mg is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 urine drug screen is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Tempur-Pedic bed is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **1 abdominal binder is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **1 Tizanidine HCL 4 mg #90 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Gabapentin 600 mg #90 is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Restoril 30 mg #30 is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for **Lactulose 10 gm/15ml solution #474 is medically necessary and appropriate.**

- 9) MAXIMUS Federal Services, Inc. has determined the request for **Lidoderm 5% 700 mg/ patch #30** is not medically necessary and appropriate.
- 10) MAXIMUS Federal Services, Inc. has determined the request for **1 IM injection of B12** is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/25/2013. 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 **1 IM injection of Toradol 60 mg is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 urine drug screen is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Tempur-Pedic bed is not medically necessary and appropriate.**
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- 10) MAXIMUS Federal Services, Inc. has determined the request for **1 IM injection of B12 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 Occupational Medicine 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 employee is a represented [REDACTED] employee who has filed a claim for chronic neck pain, chronic myofascial pain, chronic regional pain syndrome, chronic low back pain, headaches, and bilateral shoulder pain reportedly associated with an industrial injury of March 16, 1995.

Thus far, the employee has been treated with the following: Analgesic medications; adjuvant medications; prior right shoulder arthroscopy; transfer of care to and from various providers in various specialties; and extensive periods of time off of work.

In a utilization review report of July 17, 2013, the claims administrator denied a request for Toradol, denied a urine drug screen, approved a lumbar sympathetic block, denied a bed, denied an abdominal binder, denied a prescription for tizanidine, denied a prescription for Neurontin, partially certified a prescription for Restoril, certified a prescription for Nucynta, and certified a prescription for Norco, non-certified a prescription for lactulose, denied a prescription for Lidoderm, and denied a prescription for vitamin B12. In a later letter of August 7, 2013, the claims administrator appealed the denial.

An earlier note of June 24, 2013, is notable for comments that the employee reports low back pain radiating into bilateral lower extremities, bilateral upper extremity pain, and neck pain radiating to the bilateral upper extremities. The employee's pain is scored at 7/10 with medications and 10/10 without medications. The right leg is the principal source of the complaint. The employee reports limitation in performing self-care, personal hygiene, ambulating, hand function, sleep, and sex. The employee exhibits restricted range of motion about the bilateral shoulders, multifocal myofascial tenderness, and unchanged motor exam and an unchanged sensory exam. The employee is given a Toradol injection for an acute flare of pain as well as a vitamin B12 injection, also for a flare of pain. Numerous medications are refilled. The employee is asked to obtain a bed, obtain a sympathetic block, obtain topical agents, and obtain several other medication refills.

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

1) Regarding the request for 1 IM injection of Toradol 60 mg :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, specific drug list & adverse effects, Ketorlac (Toradol®), which is part of MTUS and the Official Disability Guidelines, (ODG), Pain, (Acute & Chronic), Ketorolac (Toradol®), which is not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Ketorolac (Toradol®), page 72, which is part of MTUS, and the American College of Occupational and Environmental Medicine (ACOEM), 3rd Edition, Low Back, Medications, NSAIDs and Acetaminophen, which is not part of MTUS.

Rationale for the Decision:

As noted on page 72 of the Chronic Pain Medical Treatment Guidelines, ketorolac or Toradol is not indicated for minor painful conditions. The medical records submitted for review indicate that the employee presented with an acute flare up of pain, for which an injection of Toradol was indicated. It is further noted that the Third Edition ACOEM Guidelines also endorse ketorolac, an NSAID (Non-Steroidal Anti-Inflammatory Drug), for severe musculoskeletal low back pain in the emergency department population. **Therefore, the request for 1 IM injection of Toradol 60 mg is medically necessary and appropriate.**

2) Regarding the request for 1 urine drug screen :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Opiates, steps to avoid misuse/addiction, which is part of MTUS, and the Official Disability Guidelines (ODG), Pain (Chronic), Urine Drug Testing (UDT), which is not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Drug Testing, page 43, which is part of MTUS and the Official Disability Guidelines (ODG), Pain (Chronic), Criteria for use of Urine Drug Testing, which is not part of MTUS.

Rationale for the Decision:

While page 43 of the Chronic Pain Medical Treatment Guidelines does endorse intermittent urine drug testing in the chronic pain population, the MTUS does not specifically establish parameters to performing urine drug testing or establish a frequency with which urine drug testing should be performed. As noted in the ODG Chronic Pain Chapter urine drug testing topic, the attending provider should furnish a clear list of medications that an employee is taking prior to requesting testing. The attending provider should also state precisely which urine drug panel items that are selected to be tested. In this case, the attending provider neither furnished a complete list of medications that the employee was taking, nor did he furnish a complete list of tests for which he intended to perform. **The request for 1 urine drug screen is not medically necessary or appropriate.**

3) Regarding the request for Tempur-Pedic bed :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Low Back-Lumbar & Thoracic (Acute & Chronic), Mattress selection, which is not part of MTUS.

The Expert Reviewer based its decision on American College of Occupational and Environmental Medicine (ACOEM), 3rd edition, Chronic Pain, General Principles of Treatment, Specific Treatment Interventions, Activity Modification and Exercise, which is not part of the MTUS.

Rationale for the Decision:

The MTUS does not specifically address the topic. As noted in the Third Edition ACOEM Guidelines, specific sleeping products, such as beds, mattresses, hammocks, etc., are not recommended for treatment of any chronic pain syndrome. These items are considered articles of personal preferences as opposed to medical necessity. **The request for Tempur-Pedic bed is not medically necessary or appropriate.**

4) Regarding the request for 1 abdominal binder :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based its decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), page 301, which is part of the MTUS.

Rationale for the Decision:

The MTUS does not specifically address the topic of abdominal binders. These devices are essentially now just a lumbar support. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, however, lumbar supports have not been deemed to have any lasting benefit beyond the acute phase of symptom relief. They are not recommended in the treatment of this employee's chronic low back pain as long-term usage of lumbar support would only serve to promote immobility and/or disuse here. **The request for 1 abdominal binder is not medically necessary or appropriate.**

5) Regarding the request for 1 Tizanidine HCL 4 mg #90 :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Tizanidine (Zanaflex®), and Muscle relaxants (for pain), which are part of MTUS.

The Expert Reviewer based his/her decisions on the Chronic Pain Medical Treatment Guidelines, Antispasticity/antispasmodic drugs, Tizanidine (Zanaflex®), page 66, and MTUS Definitions, (f), “Functional improvement”, which are part of MTUS.

Rationale for the Decision:

While page 66 of the MTUS Chronic Pain Medical Treatment Guidelines does weakly endorse usage of tizanidine for off-label purposes in the treatment of low back pain, in this case, the employee has used this particular agent chronically. There is no clear evidence of functional improvement as defined in MTUS 9792.20(f) through prior usage of the same. There is no evidence that the employee has returned to work, exhibits improved performance of activities of daily living, and/or diminished reliance on medical treatment through prior usage of tizanidine or other drugs. Rather, the fact that the employee remains off of work, is pursuing numerous interventional procedures such as lumbar sympathetic blocks, is using numerous analgesic and adjuvant medications, all taken together, imply a lack of functional improvement as defined in MTUS 9792.20(f). **The request for 1 Tizanidine HCL 4 mg #90 is not medically necessary or appropriate.**

6) Regarding the request for Gabapentin 600 mg #90 :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Gabapentin (Neurontin®) and Antiepilepsy Drugs (AEDs), which are part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Recommended Trial Period, page 19 and the MTUS Definitions, (f), “Functional improvement”, which are part of MTUS.

Rationale for the Decision:

As noted on page 19 of the Chronic Pain Medical Treatment Guidelines, the recommended trial period for gabapentin or Neurontin is 3 to 10 weeks. In this case, the employee has used Neurontin in amounts in excess of these parameters. There is no clear evidence of functional improvement effected through prior usage of the same. Rather, the fact that the employee continues to use numerous analgesic and adjuvant medications, pursue multiple spine procedures, and coupled with the fact that the employee has failed to return to work, imply the lack of functional improvement as defined in Section 9792.20(f). **The request for Gabapentin 600 mg #90 is not medically necessary or appropriate.**

7) Regarding the request for Restoril 30 mg #30 :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, Weaning of Medications, and Opioids, long-term assessment, which are part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, page 24 and the MTUS Definitions, (f), "Functional improvement", which are part of MUTS.

Rationale for the Decision:

Page 41 of the MTUS Chronic Pain Medical Treatment Guidelines does not endorse chronic or long-term usage of benzodiazepines, either for pain, sleep, insomnia, anxiety, antidepressant effect, or anticonvulsant effect. The medical records provided for review do not indicate a clear rationale to offset the unfavorable MTUS recommendation, nor has the attending provider established the presence of functional improvement effected through prior usage of Restoril. **The request for Restoril 30 mg #30 is not medically necessary or appropriate.**

8) Regarding the request for Lactulose 10 gm/15ml solution #474 :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the McKay SL, Fravel M, Soanlon C. Management of constipation. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Translation and Dissemination Core; 2009 Oct.9. page 51, Pharmacological Therapy, which is not part of MTUS.

The Expert Reviewer based its decision on the Chronic Pain Medical Treatment Guidelines, Initiating Therapy, (d) Prophylactic treatment, page 77, which is part of MTUS.

Rationale for the Decision:

Page 77 of the Chronic Pain Medical Treatment Guidelines explicitly endorses prophylactic treatment of constipation in those the employees using opioids chronically. In this case, the employee is an individual who is using numerous opioid medications, including Norco, chronically. Providing a laxative, in conjunction with the same, is indicated here. **The request for Lactulose 10 gm/15ml solution #474 is medically necessary and appropriate.**

9) Regarding the request for Lidoderm 5% 700 mg/ patch #30 :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Lidoderm (Lidocaine patch), which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Lidocaine Indication, page 112 and the MTUS Definitions, (f), "Functional improvement", which are part of MTUS.

Rationale for the Decision:

Review of the submitted medical records indicates that the employee was previously using Lidoderm patches on a prior note of April 29, 2013. Page 112 of the Chronic Pain Medical Treatment Guidelines does endorse usage of Lidoderm patches for localized peripheral pain/neuropathic pain after there has been unsuccessful trial of antidepressants and/or anticonvulsants. In this case, the employee has, indeed, seemingly failed oral anticonvulsants, including Neurontin. However, the employee has also used Lidoderm chronically and failed to derive any lasting benefit or functional improvement through prior usage of the same. The fact that the employee has failed to clearly return to work, continues to use numerous analgesic and adjuvant medications, continues to pursue multiple interventional procedures, and implies a lack of functional improvement as defined in Section 9792.20(f). **The request for Lidoderm 5% 700 mg/ patch #30 is not medically necessary or appropriate.**

10)Regarding the request for 1 IM injection of B12 :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2008 Edition, Vitamins , page 221-222 and the Official Disability Guidelines, (ODG), Pain (Chronic), Vitamin B, which are not part of MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine, 2008 Edition, Vitamin B12, which is not part of MTUS.

Rationale for the Decision:

The MTUS does not specifically address the topic. As noted in the 2008 ACOEM Practice Guidelines, vitamin B12 has been reported as a successful treatment for stroke employees with carpal tunnel syndrome. In this case, however, it does not appear that the employee carries the requisite diagnoses of carpal tunnel syndrome plus stroke. **The request for 1 IM injection of B12 is not medically necessary or 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.