MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

Dated: 12/30/2013

Employee:	
Claim Number:	
Date of UR Decision:	8/7/2013
Date of Injury:	6/9/2010
IMR Application Received:	8/14/2013
MAXIMUS Case Number:	CM13-0010965

DEAR

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,

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 Internal 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 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 patient is a 58 years old male, heat treater who sustained injury when he opened a counter weight door and pushing and pulling baskets out of a furnace on the date of the injury 06/09/2010. A claim for lower back pain was accepted by carrier. On july 2, 2013, Dr.[redacted] reported that the patient underwent his first lumbar epidural steroid injection on July 2, 2013, with immediate reduction in pain from 8 to 4 on a numeric scale of 0 to 10, and the lowest level of pain lasted for 2 days. He also did receive physical therapy with some additional reduction of back pain by a quarter. Chiropractic treatment was reported by the patient to be helpful. On 8/18/2011, the patient underwent a lumbar laminectomy and discectomy, and was subsequently determined to have reached maximum medical improvement. The operating surgeon found him to be permanent and stationary, and noted that the patient was able to return to work with no lifting of over 50 pounds and no repetitive bending, stooping, and twisting at the waist.

IMR DECISION(S) AND RATIONALE(S)

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

1. Lumbar epidural steroid injection L4-5 and L5-S1 is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 300, 309, which is part of MTUS.

The Physician Reviewer's decision rationale:

According to Occupational Medicine Practice Guidelines (section on Lower back Compliants, page 300,) Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidociane) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery.

In addition, MTUS (Effective July 18, 2009) Chronic Pain Medical Treatment Guidelines (page 46), stipulates that "the purpose of Epidural Steriod Injections (ESI) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit". MTUS further stated "current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." In the therapeutic phase, MTUS stated "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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)"

Dr.[redacted] reported that the patient underwent his first lumbar epidural steroid injection on July 2, 2013, with immediate reduction in pain from 8 to 4 on a numeric scale of 0 to 10, and the lowest level of pain lasted for 2 days.

2. Lumbar facet joint steroid injection L1-2, L4-5 and L5-S1 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines which is not part ogf MTUS.

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 300, 309, which is part of MTUS.

The Physician Reviewer's decision rationale:

According to Occupational Medicine Practice Guidelines (section on Lower back Compliants, page 300 and 309,) Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidociane) are of questionable merit. Therapeutic facet joint injections are not recommended for acute, subacute, or chronic LBP due to insufficient evidence of efficacy. (Level of evidence is C=Limited research-based evidence (at least one adequate scientific study of patients with low back complaints). This patient had chronic lower back pain due to work related injury and had underwent a lumbar laminectomy and discectomy, and was subsequently determined to have reached maximum medical improvement. The operating surgeon found him to be permanent and stationary, and noted that the patient was able to return to work with no lifting of over 50 pounds and no repetitive bending, stooping, and twisting at the waist.

3. Amitiptyline 6% dextromethorphan 30% tramadol 10% 180g, QTY: 4 is not medically necessary and appropriate.

The Claims Administrator based its decision on the MTUS 2009 Chroinic pain treatment guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg. 111, which is part of MTUS.

The Physician Reviewer's decision rationale:
MTUS (Effective July 18, 2009) Chronic Pain Medical Treatment Guidelines (pages 111), Topical analgesics , largely experimental in use with few randomized controlled trials to determine efficacy or safety, are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug nteractions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control. There is little or no research to support the use of many of these agents. Any compound product that contains at least one drug (or drug class) that is not recommended is not recommended. Although the MTUS does not address the specific components of this compound (Amitiptyline 6% dextromethorphan 30% tramadol 10% 180g, QTY: 4.00), it did indicate that topical analgesic agents are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. This patient had chronic lower back pain due to work related injury and had underwent a lumbar laminectomy and discectomy, and was subsequently determined to have reached maximum medical improvement. The operating surgeon found him to be permanent and stationary, and noted that the patient was able to return to work with no lifting of over 50 pounds and no repetitive bending, stooping, and twisting at the waist. There is no mention of neuropathic pain syndrome in the medical records reviewed.

4. Ultram 50mg #40 is not medically necessary and appropriate.

The Claims Administrator did not cite and evidence basis for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg 75, 80, 84 which is part of MTUS.

The Physician Reviewer's decision rationale:

MTUS (Effective July 18, 2009) Chronic Pain Medical Treatment Guidelines (pages 75, 80 and 84), Tramadol (Ultram)- classified as a small class of synthetic opioids, with opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine as a Central acting analgesics. This class of synthetic opioids have been reported to be effective in managing neuropathic pain, with side effects similar to traditional opioids. "Opioids efficacy is limited to short term pain relief, and long term efficacy is unclear". Failure to respond to a time-limited course of opioids has led to suggestion of reassessment and consideration of alternative therapy. A recent Cochrane review found that Ultram decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Adverse events often caused study participants to discontinue this medication, and could limit usefulness. Therefore the prescription of 480 tablets of Ultram 50mg initially appears to be excessive and 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.

[redacted]

CM13-0010965