

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

December 27, 2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/23/2013
Date of Injury: 4/20/2001
IMR Application Received: 8/16/2013
MAXIMUS Case Number: CM13-0011037

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 Anesthesiology, has a subspecialty in Pain 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 46-year-old male who reported an injury on 04/20/2001. He is noted to have undergone a back surgery in 2003 followed by hardware removal in 2004 with an additional fusion in 09/2004. The patient is reported to complain of pain in his cervical spine with burning pain in his upper extremities, burning pain in his low back, with burning pain in the back of his left leg. He is noted to utilize a rolling walker for ambulation and to wear bilateral wrist splints. He was reported to have been under the care of a psychologist. A clinical note signed by Dr. [REDACTED] on 04/10/2013 reported the patient had tenderness to palpation of the cervical and thoracic region paravertebral muscles with reduced range of motion. He is noted to wear bilateral wrist splints with thumb Spica supports with decreased grip strength and to have lumbar spine tenderness, spasms, pain, and tightness in the paravertebral muscles. The patient is noted to have been given an IM Toradol injection and an IM B12 injection on that date. The patient is noted to have undergone a urinalysis which was reported to be consistent with the patient's medications. A clinical note dated 06/19/2013 signed by Dr. [REDACTED] reported the patient continued to have significant low back symptomatology with radiation to the lower extremities with constant numbness and tingling to the lower extremities. He had persistent cervical spine pain with radiation to the upper extremities and bilateral hand symptomatology. The patient is noted to have reduced motion of the cervical spine with spasm and tenderness over the paraspinal musculature, to be wearing a thumb Spica brace bilaterally. Examination of the lumbar spine reported findings of spasm and tenderness in the paraspinal muscles with reduced motion. The patient is noted to have walked with a rollator. The patient was given 2 IM injections on that date, the first consisting of 2 mL of Toradol, and the second consisting of a B12 complex and a urine drug screen was obtained on that date.

IMR DECISION(S) AND RATIONALE(S)

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

1. 1 prescription of Gabapentin 600mg #120 is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antiepilepsy drugs, pages 16-17, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The patient reported an injury on 04/20/2001. He is noted to have undergone a back surgery in 2003 followed by a removal of hardware in 2004 and then a fusion in 09/2004. He is reported to complain of ongoing neck pain with radiation of pain to the bilateral upper extremities with numbness, tingling, and ongoing pain in his low back with radiation of pain to his left lower extremity with findings of tenderness, paraspinal muscle spasms, and tightness in the cervical spine and the lumbar spine. The California MTUS Guidelines recommend the use of gabapentin as a first line treatment for neuropathic pain. Although the patient is reported to have complaints of radiation of pain with numbness and tingling to his bilateral upper and lower extremities, there are no physical exam findings of neurological deficits that would support the diagnosis of neuropathy. As such, the requested gabapentin does not meet guideline recommendations. **The request for 1 prescription of Gabapentin 600 mg #120 is not medically necessary and appropriate.**

2. 1 prescription of Hydrocodone/APAP 10/325mg #60 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, Opioids, criteria for use, page 78, and Opioids for chronic pain, page 80, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The patient reported an injury on 04/20/2001. He is reported to have a history of previous lumbar surgery, first in 2003 followed by a hardware removal in 2004 and then a fusion in 09/2004. He is reported to complain of ongoing low back pain with radiation of pain to his bilateral lower extremities and to complain of neck pain with radiation of pain to his bilateral upper extremities. He is noted to be wearing bilateral wrist splints with thumb Spica supports with decreased grip strength and is noted to have paravertebral muscle spasms, tenderness, and tightness of the lower lumbar spine and cervical and thoracic paravertebral muscle tenderness on palpation with reduced range of motion. The patient is noted to have been utilizing hydrocodone/APAP for treatment of his ongoing pain. The California MTUS Guidelines state that there should be ongoing review and documentation of the patient's current pain, what pain relief is received with use of narcotic analgesics, the patient's functional status, and appropriate medication use and side effects and notes that satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The patient is reported to complain of pain; however, his pain is not rated on a VAS scale, there is no documentation that the patient receives pain relief with the use of the hydrocodone/APAP, there are no reports that the patient's functional status improves with the use of the medication or that he has improved quality of life with the use of medication. In addition, there is no indication that the patient has been assessed for possible side effects. In addition, the California MTUS Guidelines do not recommend long-term use of opioid analgesics for treatment of neuropathic

pain or chronic back pain. They recommend only short-term use stating that long-term efficacy is unclear but appeared to be limited. **The request for hydrocodone/APAP 10/325 mg #60 is not medically necessary and appropriate.**

3. 1 IM injection of 2cc of Toradol 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, NSAIDs, page 72, which is part of the MTUS, and the Official Disability Guidelines (ODG), Pain Chapter, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The patient reported an injury on 04/20/2001. He is noted to have undergone a lumbar surgery in 2003, a hardware removal on an unstated date in 2004, and a lumbar fusion in 09/2004. He is reported to complain of ongoing cervical pain with radiation of pain to the bilateral upper extremities and lumbar pain with radiation of pain to the bilateral lower extremities. On physical exam, the patient had tenderness of the cervical and thoracic paravertebral muscles with reduced range of motion and was noted to wear bilateral wrists splints with thumb Spica supports with decreased strength and to have lumbar spine tenderness, spasms, and tightness in the lumbar paravertebral musculature. The CA MTUS Guidelines indicate that Toradol is not indicated for minor or chronic painful conditions. The Official Disability Guidelines indicate that Toradol when administered intramuscularly may be used as an alternative to opioid therapy. The patient is noted to have been given an injection of Toradol on each visit documented by Dr. [REDACTED] and to continue to use opioid analgesics for treatment of his pain. As such, the need for an IM Toradol injection is not established and it is not recommended for chronic pain. The use of Toradol injections does not meet guideline recommendations. **The request for 1 IM injection of 2cc of Toradol is not medically necessary and appropriate.**

4. 1 urinalysis is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the the Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use, page 78, which is part of the MTUS

The Physician Reviewer's decision rationale:

The patient reported an injury on 04/20/2001. He is noted to have undergone a lumbar surgery in 2003, followed by a hardware removal in 2004 on an unstated date, and an additional lumbar fusion in 09/2004. He is reported to complain of ongoing chronic neck pain with radiation of pain to the bilateral upper extremities and chronic low back pain with radiation of pain to the bilateral lower extremities with tenderness to palpation over the cervical, thoracic, and lumbar spine with spasms and tightness of the lumbar paravertebral musculature. The patient is noted to have been prescribed hydrocodone for treatment of his low back pain. The California MTUS Guidelines recommends the use of random drug screens for patients on long-term opioids. The patient is noted to have undergone a urine drug screen on 04/10/2012 and there is no indication that the patient is suspected of aberrant drug taking behaviors or addiction. As such, the need for

a repeat drug screen at this time is not indicated. **The request for a urinalysis is not medically necessary and appropriate.**

5. 1 transportation to and from all office visits is not medically necessary and appropriate.

The Claims Administrator based its decision on the Labor code 4600(a), which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on California Code of Regulations[CCR], Title 22, Section 51323, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The patient reported an injury on 04/20/2001. He is reported to complain of ongoing low back pain with radiation of pain down to the bilateral lower extremities and neck pain with radiation of pain to the bilateral upper extremities, wrist pain, and is noted to wear bilateral thumb Spica wrist splints. The California MTUS/ACOEM and ODG do not address. The California Code of Regulations, Title 22, indicates that ambulance and other medical transportation is only indicated when public or private conveyance is medically contraindicated and transportation is required to obtain needed medical care. There is no documentation that the patient lacks family members or friends that can transport the patient to and from doctors visits and there is no documentation as to why the patient cannot use public transportation and there is no indication that transportation by a public or private vehicle would be contraindicated due to the patient's medical condition. The request for transportation to and from all office visits is not medically necessary and appropriate.

6. 1 prescription of TGHOT cream #180gm is not medically necessary and appropriate.

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

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

The Physician Reviewer's decision rationale:

The patient reported an injury on 04/20/2001. He is noted to have undergone a lumbar surgery in 2003, a removal of hardware in 2004, and a lumbar fusion in 09/2004. He is reported to complain of ongoing neck pain with radiation of pain and numbness and tingling to his bilateral upper extremities and low back pain with radiation of pain to his bilateral lower extremities. The patient is noted on physical exam to be wearing bilateral wrists braces with thumb Spica attachments, to have limited range of motion of the cervical spine with tenderness to palpation of the thoracic and cervical spine paravertebral musculature. He is noted to have findings of lumbar spine tenderness, spasm, and tightness in the paravertebral musculature. The patient is prescribed TGHOT cream. The California MTUS Guidelines state that there is little to no research to support the use of many topical agents and that any compounded product that contains at least 1 drug or drug class that is not recommended, is not recommended. As there is no indication of the ingredients of the TGHOT cream, the medical necessity of the topical medication cannot be established. As such, the requested TGHOT cream does not meet guideline

recommendations. **The request for 1 prescription of TGHot cream #180 grams is not medically necessary and appropriate.**

7. 1 prescription of Fluriflex cream #180gm is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-113, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The patient reported an injury on 04/20/2001. He is reported to complain of ongoing cervical pain with radiation of pain to his bilateral lower extremities, bilateral hand pain, and ongoing chronic lumbar pain with radiation of pain to his bilateral lower extremities and is reported to complain of numbness and tingling in both the upper and lower extremities. On physical exam, he is noted to have limited range of motion of the cervical and thoracic spine with tenderness to palpation over the paravertebral musculature. He is noted to have tenderness over the lumbar spine with muscle spasms and tightness. The patient has been prescribed FluriFlex cream which contains flurbiprofen and cyclobenzaprine. The California MTUS Guidelines recommend nonsteroidal anti-inflammatories for short-term treatment of osteoarthritis and is indicated for joints that are amendable to topical treatment which does not include the spine, hip, or shoulder and they do not recommend the use of topical muscle relaxants as there is no evidence for use of any muscle relaxants as a topical product. As such, the request for FluriFlex cream 180 grams does not meet guideline recommendations as it contains a topical nonsteroidal anti-inflammatory and a topical muscle relaxant. **The request for 1 prescription for FluriFlex cream #180 grams is not medically necessary and appropriate.**

8. 1 IM injection of 2cc of vitamin B12 complex 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 Official Disability Guidelines (ODG), Pain Chapter, vitamin B, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The patient reported an injury on 04/20/2001. He is reported to have undergone a lumbar surgery in 2003, followed by a hardware removal and then a lumbar fusion in 09/2004. He is noted to complain of ongoing neck pain with radiation of pain to the bilateral upper extremities with numbness and tingling and low back pain with radiation of pain to the bilateral lower extremities with numbness and tingling. He is noted on physical exam to have limited range of motion of the cervical and thoracic spine with tenderness to palpation of the paravertebral musculature. He is noted to have tenderness of the lumbar spine to palpation with spasms and tightness of the paravertebral musculature. The California MTUS Guidelines do not address the use of vitamin B12. The Official Disability Guidelines state that the use of vitamin B is not recommended noting that vitamin B is frequently used to treat peripheral neuropathy but its efficacy is not clear and there is only limited data in randomized trials testing the efficacy of vitamin B for treatment of peripheral neuropathy and the evidence is insufficient to determine whether vitamin B is beneficial or harmful. The patient is noted to be receiving vitamin B injections intramuscularly; however, the guidelines do not recommend it for treatment of chronic pain. As such, the requested vitamin B injection does not meet guideline recommendations. **The**

request for 1 IM injection of 2cc of vitamin B12 complex is not medically necessary and appropriate.

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[REDACTED]

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