

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **12/12/2013**

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/13/2013
Date of Injury: 5/13/2008
IMR Application Received: 8/20/2013
MAXIMUS Case Number: CM13-0014388

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Terocin pain lotion 4oz #1 between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 transforaminal epidural steroid injection at right L4 and L5 between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **1 lab test including med panel, DBC, renal and liver functions between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol 150mg, #60 between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **eight (8) chiropractic manipulation treatments between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/20/2013 disputing the Utilization Review Denial dated 8/13/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/26/2013. 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 **Terocin pain lotion 4oz #1 between 7/8/2013 and 10/8/2013** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 transforaminal epidural steroid injection at right L4 and L5 between 7/8/2013 and 10/8/2013** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **1 lab test including med panel, DBC, renal and liver functions between 7/8/2013 and 10/8/2013** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol 150mg, #60 between 7/8/2013 and 10/8/2013** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **eight (8) chiropractic manipulation treatments between 7/8/2013 and 10/8/2013** 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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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:

This claimant is a 46-year-old female with a reported date of injury of 05/13/2006. Mechanism of injury is not provided for this review. She was seen on 07/23/2012 for complaints of pain related to her low back. She had been scheduled for a spinal injection at that time and was using tramadol 50 mg twice a day. Objectively, she had excellent range of motion of her ankle with full strength in dorsiflexion, plantarflexion and eversion and inversion. She was 18 months status post right peroneus brevis tendon repair at that time. She underwent a transforaminal epidural steroid injection right L4 and L5 on 07/27/2012. On 10/02/2012, she was seen back for evaluation with complaints of pain. Medications at that time included tizanidine 4 mg and tramadol 50 mg. Laboratory analysis in 11/2012 revealed glucose to be elevated at 114. On 03/20/2013, she was continued with tramadol and Zanaflex for muscle spasms and ketoprofen cream as needed. Pain was rated at 4/10 at that time. She was seen next on

09/11/2013 at which time she was taking tramadol 150 mg as needed and Flexeril for spasms. Pain was rated at 6/10 at that time. Diagnoses include severe lumbar facet syndrome, retrolisthesis L5 and S1, potential psychological issues including depression, anxiety and sleep deprivation, multilevel degenerative disc disease of the lumbar spine with radiculopathy, facet arthropathy at L4-5 with canal stenosis and status post peroneus brevis tendon repair with tubulization without fibular groove deepening. Plan at that time was to continue with medications including Terocin pain lotion, 1 transforaminal epidural steroid injection right L4 and L5, 1 lab test including metabolic panel, TBC, renal and liver function, 1 prescription of tramadol 150 mg #60, and 1 request for 8 chiropractic manipulation treatments.

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 Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for Terocin pain lotion 4oz #1 between 7/8/2013 and 10/8/2013:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

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

Rationale for the Decision:

The rationale for why the requested treatment is or is not medically necessary is that this is a topical analgesic containing capsaicin, lidocaine and menthol or methyl salicylate. Chronic Pain Medical Treatment Guidelines, Page 111, indicates that topical analgesics are “largely experimental in use with few randomized controlled trials to determine efficacy or safety.” Guidelines indicate this type of medication is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed, and that “any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended.” Specifically, capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Lidocaine is a component of Terocin lotion and it is “recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI

antidepressants or AED such as gabapentin or Lyrica).” Guidelines indicate that further research is needed to recommend that this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia, and that “systemic exposure was highly variable among patients.” Medical records submitted and reviewed indicate this employee continues to report pain anywhere from 4/10 to 6/10 with tramadol and Flexeril with the latest pain being rated at 6/10 as of 09/11/2013. There is no indication the employee has postherpetic neuralgia nor has failed from the use of lesser medications such as AED, tricyclic, or an SNRI. **The request for Terocin pain lotion 4oz #1 between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.**

2) Regarding the request for 1 transforaminal epidural steroid injection at right L4 and L5 between 7/8/2013 and 10/8/2013:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment guidelines(2009), which is part of the MTUS.

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

Rationale for the Decision:

The rationale for why the requested treatment, a second transforaminal epidural steroid injection at right L4 and L5, is not considered medically necessary is that MTUS Chronic Pain Guidelines indicate that “radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.” Patients should be initially unresponsive to conservative treatments such as exercises, physical methods, NSAIDs, and muscle relaxants. In the therapeutic phase, repeat blocks, per MTUS Chronic Pain Guidelines, should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The submitted records indicate this employee underwent an epidural steroid injection at L4 and L5 on 07/27/2012. The employee returned on 07/31/2012 and reported pain at 0/10 at that time. The employee reported the ability to decrease medication usage. The employee returned on 10/02/2012 and reportedly was doing better but was still taking Tramadol 50 mg., twice a day as needed as well as Zanaflex. The employee did show some improvement but the records did not indicate there was a 50% improvement for 6 to 8 weeks as per MTUS Chronic Pain Guidelines. Furthermore, the records provided for this review did not include objective evidence of radiculopathy as electrodiagnostic studies and imaging studies were not provided for this review to objectively document that the employee currently has radiculitis on objective testing. Therefore, radiculopathy has not been currently documented by imaging studies and/or electrodiagnostic studies and there is lack of documentation of 50% pain relief of 6 to 8 weeks as per Chronic Pain Guidelines. **The request for 1 transforaminal epidural steroid injection**

at right L4 and L5 between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.

3) Regarding the request for 1 lab test including med panel, DBC, renal and liver functions between 7/8/2013 and 10/8/2013:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, pg. 70, which is part of the MTUS

Rationale for the Decision:

The rationale for why the requested treatment is not medically necessary is this request is for lab tests including metabolic panel, DBC, liver function between 07/08/2013 and 10/08/2013. In MTUS Chronic Pain Guidelines, in discussing NSAIDs, the authors indicate that nonsteroidal anti-inflammatory use is recommended with caution in patients with moderate hepatic impairment and not recommended in patients with severe hepatic impairment. Borderline elevations of 1 or more liver enzymes, per MTUS Chronic Pain Guidelines, may occur in up to 15% of patients taking NSAIDs. In discussing monitoring, MTUS Chronic Pain Guidelines, Page 70, indicate that package inserts for NSAIDs recommend periodic lab monitoring of CBC and chemistry profile including liver and renal function tests. The medical records submitted for this review indicate that as of 09/11/2013, this employee was on tramadol and Flexeril as needed for muscle spasms. The records do not indicate that the employee is currently on any nonsteroidal anti-inflammatory medications. Laboratory analysis was performed on 11/29/2012 and indicated that everything was within normal limits except for glucose which was elevated at 114. Lacking documentation of nonsteroidal anti-inflammatory use at this time, there is no indication for this level of lab testing.

The request for 1 lab test including med panel, DBC, renal and liver functions between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.

4) Regarding the request for Tramadol 150mg, #60 between 7/8/2013 and 10/8/2013:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Tramadol, pg. 113, which is part of the MTUS.

Rationale for the Decision:

The rationale for why tramadol is not medically necessary is that the records indicate this employee has been on this medication for a significant length of time. The employee still rates the pain as of 09/11/2013 at 6/10 with this medication. MTUS Chronic Pain Guidelines indicate that tramadol, a centrally acting synthetic opioid analgesic, is not recommended as a first line oral analgesic. The records indicate the employee has been on this medication for a significant length of time and does not indicate a failure from the use of less medication. As a centrally acting synthetic opioid analgesic, the "4 A's" should be monitored. The "4 A's" include, activities of daily living, aberrant drug taking behavior, analgesia, and adverse side effects. Although the records do not indicate the employee has had significant adverse side effects, there has been lack of urine drug screens to indicate that the employee has not been aberrant with this medication. The employee still has pain rated at 6/10, so analgesia has not been effectively controlled. **The request for Tramadol 150mg, #60 between 7/8/2013 and 10/8/2013 is not medically necessary and appropriate.**

5) Regarding the request for eight (8) chiropractic manipulation treatments between 7/8/2013 and 10/8/2013:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation, pgs. 58-59.

Rationale for the Decision:

The rationale for why this requested treatment is not medically necessary is this request is for 8 chiropractic treatments. MTUS Chronic Pain Guidelines indicate that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. However, treatment parameters would include time to produce effect would be 4 to 6 treatments and frequency of 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. Maximum duration is 8 weeks. Specifically for the low back, for therapeutic care, a trial of 6 weeks over 2 weeks is recommended and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be considered reasonable. For elective or maintenance care, guidelines do not indicate manipulation or manual therapy is medically necessary. If there is recurrence or flare ups, the need to re-evaluate treatment success, if return to work is achieved, then 1 to 2 visits every 4 to 6 months may be considered reasonable per MTUS Chronic Pain Guidelines. Medical records submitted and reviewed do not indicate this employee has returned to work and the request exceeds current guideline recommendations. **The request for eight (8) chiropractic manipulation treatment between 7/8/2013 and 10/8/2013 is not medically necessary and 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

/sb

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.