

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

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[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/31/2013

IMR Case Number:	CM13-0018508	Date of Injury:	07/06/2010
Claims Number:	[REDACTED]	UR Denial Date:	08/26/2013
Priority:	STANDARD	Application Received:	08/29/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] MD		
Treatment(s) in Dispute Listed on IMR Application:			
MRI LUMBAR SPINE, INITIAL ACUPUNCTURE FOR L/5 AND TEROGIN LOTION			

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]
[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 Orthopedic Surgery, has a subspecialty in Spine Surgery 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 39-year-old male who reported an injury to his low back on 07/06/2010. He is noted to have undergone an L5-S1 laminectomy and discectomy on 03/11/2011 and an anterior lumbar interbody fusion at L5-S1 on 03/07/2012. He is noted to have treated postoperatively with extensive physical therapy, chiropractic manipulations, and to have begun acupuncture on 07/26/2013 for an unknown number of sessions. The clinical note dated 07/18/2013 reported the patient completed 14 sessions of chiropractic/physiotherapy which he reported was helping decrease his pain. He complained of back pain rated 7/10; left lower extremity numbness, tingling, and pain to the foot. He was noted at that time to be utilizing Medrox patches that helped decrease his pain and increase his level of function. On physical exam, the patient is noted to have a mildly antalgic gait, to have tenderness to the bilateral paraspinal muscles, decreased left L4, L5, and S1 sensation to pinprick and light touch, and decreased strength of the left anterior tibialis, EHL, inversion, plantar flexion, and eversion. The patient is noted to have undergone multiple x-rays since his lumbar fusion which noted a stable solid fusion. He is noted to have undergone an electrodiagnostic study on 04/10/2013 which was reported to be normal with no findings of radiculopathy.

IMR DECISION(S) AND RATIONALE(S)

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

1. MRI Lumbar Spine is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines for the low back regarding Special Studies and Diagnostic and Treatment Considerations chapter 12 page 303, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pages 303-305, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines state MRIs are recommended of unequivocal objective findings that identify nerve root compression on neurological examination for patients who have not responded to treatment and would consider surgery an option. However, as the employee is noted to have had no change in neurological examination since prior to the employee's fusion operation on 08/07/2012 and there is no indication the employee is being planned for additional surgery and as the employee has hardware in the lumbar spine which would affect the reading of the MRI, the repeat MRI of the lumbar spine does not meet guideline recommendations. **The request for MRI Lumbar Spine is not medically necessary and appropriate.**

2. Initial Acupuncture for L/S is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Acupuncture Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS Acupuncture Guidelines recommend the use of acupuncture when pain medications are being reduced or not tolerated as an adjunct to physical rehabilitation or surgical intervention to hasten function recovery. The Guidelines recommend a trial of 6 sessions and state if there is no functional improvement documented indicating a clinically significant improvement in ability to perform activities of daily life, a reduction in work restrictions, and reduction in dependence on continued medical treatment, the need for additional acupuncture is not indicated. In the medical records provided for review the employee is not noted to be increasing or intolerant to prescribed medications, nor is the employee noted to have been continuing physical therapy at the time of the request. As such, the requested acupuncture does not meet guideline recommendations. **The request for Initial Acupuncture for L/S is not medically necessary and appropriate.**

3. Terocin Lotion 40z is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines section on Topical Analgesics pages 111-113, which is part of the MTUS.

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

The Physician Reviewer's decision rationale:

MTUS Chronic Pain Guidelines state topical non-steroidal anti-inflammatories are recommended for treatment of osteoarthritis and tendinitis in joints that are mendable to topical treatment for short-term use. The Guidelines state lidocaine is indicated for treatment of neuropathic pain, but only after a treatment of first-line therapy and only in the form of Lidoderm patches noting that no other commercially-approved formulation of lidocaine, whether a cream, lotion, or gel, is indicated for neuropathic pain. Guidelines state capsaicin is only recommended as an option for patients who have not responded or are intolerant to other treatments. As the Terocin lotion contains methyl salicylate and the employee is being treated for the low back, the non-steroidal anti-inflammatory is not indicated as it contains lidocaine which is indicated for neuropathic pain. There is no documentation provided for review that the employee has not responded or is intolerant to other treatments and as such, the requested Terocin lotion does not meet guideline recommendations. **The request for Terocin lotion 40z is not medically necessary and appropriate.**

/MCC

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]

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