
Notice of Independent Medical Review Determination

Dated: 9/23/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/1/2013
Date of Injury: 9/20/2010
IMR Application Received: 7/15/2013
MAXIMUS Case Number: CM13-0001439

- 1) MAXIMUS Federal Services, Inc. has determined the request for 6 months of pool pass **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Promolaxin 100mg #100 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Terocin lotion **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for transcutaneous electronic nerve stimulator (TENS) unit patches **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/15/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/17/2013. 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 6 months of pool pass **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Promolaxin 100mg #100 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Terocin lotion **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for transcutaneous electronic nerve stimulator (TENS) unit patches **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 Physical Medicine and Rehabilitation, 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 1, 2013

“The patient is a 28 year old male with a date of injury of 9/20/2010. This are prospective request for 1 follow up with Dr. [REDACTED] 6 months of pool pass, 1 prescription of naproxen 550mg #60, 1 prescription omeprazole 20mg #60, 1 prescription of promolaxin 100mg #100, 1 prescription of Terocin lotion, 1 TENS unit patches.

“A review of the submitted documents indicate that the patient is being treated for low back pain and is status post surgical among other complaints. On 6/20/13 the patient was seen and stated that he continues to have low back pain with radiation to the lower extremities. He also states that when doing water exercises he felt more stable walking, and that currently his constipation has been controlled and that he has no new incontinence issues and it down to using only one catheter per day. Objectively stated is that his low back is tender to palpation at this time.”

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 for Independent Medical Review (received 7/15/13)
- Utilization Review Determination (dated 7/1/13)
- California Chronic Pain Management Guidelines (2009), Aquatic therapy, pg 12
- California Chronic Pain Management Guidelines (2009), NSAIDs, GI symptoms & cardiovascular risk, pg 58
- California Chronic Pain Management Guidelines (2009), Capsaicin, topical, pg. 28-29
- California Chronic Pain Management Guidelines (2009), Transcutaneous electrotherapy, pgs. 104-107
- Medical Records from [REDACTED] (dated 7/16/12-6/20/13)
- Medical Records from [REDACTED] (dated 7/13/12-5/16/13)
- Medical Records from [REDACTED] (dated 5/30/12-6/14/13)
- PR-2 Reports from [REDACTED] (dated 7/11/12-4/11/13)
- Medical Records from [REDACTED] (dated 10/15/12)
- PR-2 Reports from [REDACTED], P.A. (dated 4/23/13-5/21/13)
- Physical Therapy Initial Examination from [REDACTED] (dated 12/14/12)
- Imaging Report of the lumbar spine from [REDACTED] (dated 9/11/12)

1) Regarding the request for 6 months of pool pass :

Medical Treatment Guideline(s) 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), Aquatic Therapy, page 12, part of the Medical Treatment Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on September 20, 2010 to the lower back. The medical records submitted for review indicate diagnoses of lumbar region injury, dysuria, myofascial pain, and status postsurgical for lumbar region. Treatments have included urodynamic study, surgical intervention at L4-L5, and medication management. The request is for a 6 months of pool pass.

The MTUS Chronic Pain guidelines recommend aquatic therapy as an option and an alternative to land-based physical therapy. The medical records provided for

review do not document failure of land-based physical therapy, home exercises, or need for specialized equipment. Therefore, the request for 6 months of pool pass **is not medically necessary and appropriate.**

2) Regarding the request for Omeprazole 20mg #60 :

Medical Treatment Guideline(s) 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), pg. 58, part of the Medical Treatment Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on September 20, 2010 to the lower back. The medical records submitted for review indicate diagnoses of lumbar region injury, dysuria, myofascial pain, and status postsurgical for lumbar region. Treatments have included urodynamic study, surgical intervention at L4-L5, and medication management. The request is for Omeprazole 20 mg #60.

The MTUS Chronic Pain guidelines recommend proton pump inhibitors for individuals at risk for gastrointestinal (GI) events while taking nonselective nonsteroidal anti-inflammatory (NSAIDs) medication. The medical records provided for review do not indicate the employee had adverse effects due to taking NSAIDs. The request for Omeprazole 20 mg #60 **is not medically necessary and appropriate.**

3) Regarding the request for Promolaxin 100mg #100 :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite and evidence basis for its decision. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer found that no section of the Medical Treatment Utilization Schedule (MTUS) addressed the issue at dispute. The Expert Reviewer found no applicable and relevant Medical Treatment Guideline addressed the issue at dispute. 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 information from Drugs.com, as a Nationally Recognized Professional Standard for the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on September 20, 2010 to the lower back. The medical records submitted for review indicate diagnoses of lumbar region injury, dysuria, myofascial pain, and status postsurgical for lumbar

region. Treatments have included urodynamic study, surgical intervention at L4-L5, and medication management. The request is for Promolaxin 100 mg #100.

MTUS only addresses stool softeners for the management of opioid-induced constipation treatment. The medical records provided for review indicate the employee has urinary incontinence from previously diagnosed cauda equina syndrome, and has been instructed to avoid constipation as straining would cause further incontinence. Drugs.com indicates Promolaxin can be used effectively for the relief from occasional constipation. The request for Promolaxin 100 mg #100 **is medically necessary and appropriate.**

4) Regarding the request for Terocin lotion :

Medical Treatment Guideline(s) 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), Capsaicin, topical, pages 28-29, part of the Medical Treatment Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on September 20, 2010 to the lower back. The medical records submitted for review indicate diagnoses of lumbar region injury, dysuria, myofascial pain, and status postsurgical for lumbar region. Treatments have included urodynamic study, surgical intervention at L4-L5, and medication management. The request is for Terocin lotion.

The MTUS Chronic Pain guidelines state Lidocaine is only recommended in the form of a dermal patch and other formulations of lidocaine whether cream, lotion, or gels are not approved for pain. Terocin is a compounded topical lotion that contains Lidocaine. The request for Terocin lotion **is not medically necessary and appropriate.**

5) Regarding the request for transcutaneous electronic nerve stimulator (TENS) unit patches :

Medical Treatment Guideline(s) 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), Transcutaneous electrotherapy, pages 104-107, part of the Medical Treatment Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on September 20, 2010 to the lower back. The medical records submitted for review indicate diagnoses of lumbar region injury, dysuria, myofascial pain, and status postsurgical for lumbar region. Treatments have included urodynamic study, surgical intervention at L4-L5, and medication management. The request for transcutaneous electronic nerve stimulator (TENS) patches.

The MTUS Chronic Pain guidelines indicates specific criteria for a TENS unit that includes documentation of a one-month trial of TENS. However, in this case, the documentation lacks the evidence of a trial of TENS unit. The request for transcutaneous electronic nerve stimulator (TENS) patches **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

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.