
Notice of Independent Medical Review Determination

Dated: 10/4/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/10/2013

12/30/2009

7/22/2013

CM13-0002314

- 1) MAXIMUS Federal Services, Inc. has determined the request for urine drug screen test - next office visit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for gabapentin 600mg 1/2 HS #30 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for hydrocodone Bit/PAPA tid #90 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for tramadol ER 150mg QD #30 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Exoten-C lotion **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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 urine drug screen test - next office visit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for gabapentin 600mg 1/2 HS #30 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for hydrocodone Bit/PAPA tid #90 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for tramadol ER 150mg QD #30 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Exoten-C lotion **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 & 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 10, 2013:

"Clinical Features:

- a. The patient is a 55 year old male s/p injury 12/30/09, now 3 Y, years ago. 7/10/2013
- b. Note is made that Labor Code 4610 and California Code of Regulations 9792.6 et seq, make no provision for specialty match in utilization review.
- c. 6/18/2013 Dr. [REDACTED] MD PR-2: Subj- Complains of low back pain radiates to the left lower extremity to the level of the foot, neck pain radiates to the left upper extremity. Pain levels average VAS 4/10 with medications, without 8/10, also has difficulty using right hand secondary to pain, wants additional surgery.
- d. Obj- Had limited response to LESI and physical therapy. He is alert in moderate distress, moderate reduction in lumbar ROM, spinal vertebral tenderness L4-S1, myofascial tenderness, sensory and motor revealed no change, SLR seated positive 70 degrees left lower extremity, positive allodynia right hand, s/p amputation PIP 1-3 digits."

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 7/22/2013)
- Utilization Review from [REDACTED] (dated 7/10/2013)
- Medical Records provided by the Claims Administrator
- Medical Treatment Utilization Schedule

1) Regarding the request for urine drug screen test - next office visit:

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), (online version), Pain Chapter, Urine Drug Testing, a medical treatment guideline (MTG), not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Drug testing, page 43, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 12/30/09 the employee sustained a work-related injury. The submitted and reviewed medical records document constant low back pain with radiation to the bilateral lower extremities to the level of the toes, with numbness and tingling. Treatment has included: medications, physical therapy, TENS unit, chiropractic care, right shoulder injection, and lumbar epidural steroid injection. The records indicate diagnoses of lumbar radiculitis, depression, anxiety, right shoulder pain, right hand pain, chronic pain trauma, right index finger and middle finger PIP level amputation, right thumb amputation through distal phalanx, right ring finger distal tuft fracture with nail bed injury, history of gastric ulcers, and erectile dysfunction. A request has been submitted for urine drug screen test - next office visit.

MTUS Chronic Pain Guidelines recommend drug testing as an option to assess for the use or the presence of illegal drugs. The submitted records note that a drug panel dated 7/18/13 revealed test results were not consistent with the prescribed medications but there was no documentation stating this was addressed with the employee. The records do not provide a complete rationale for the necessity of this test. The guidelines do not support the requested testing in this case. The requested urine drug screen test next office visit **is not medically necessary and appropriate.**

2) Regarding the request for gabapentin 600mg 1/2 HS #30:

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 Guidelines, (2009), Antiepilepsy drugs, pg. 16, part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, (2009), Antiepilepsy drugs, pg. 16 and Gabapentin, pg. 49, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 12/30/09 the employee sustained a work-related injury. The submitted and reviewed medical records document constant low back pain with radiation to the bilateral lower extremities to the level of the toes, with numbness and tingling. Treatment has included: medications, physical therapy, TENS unit, chiropractic care, right shoulder injection, and lumbar epidural steroid injection. The records indicate diagnoses of lumbar radiculitis, depression, anxiety, right shoulder pain, right hand pain, chronic pain trauma, right index finger and middle finger PIP level amputation, right thumb amputation through distal phalanx, right ring finger distal tuft fracture with nail bed injury, history of gastric ulcers, and erectile dysfunction. A request has been submitted for gabapentin 600mg 1/2 HS #30.

MTUS Chronic Pain Guidelines indicate gabapentin is effective for the treatment of diabetic neuropathy and postherpetic neuralgia and may be considered as a first-line treatment of neuropathic pain. The guidelines further state that continued use of antiepileptic medications (gabapentin) is dependent upon improved outcomes vs. tolerability of adverse effects. The submitted and reviewed medical records indicate that the employee was prescribed this medication on 6/18/13 but the records do not demonstrate efficacy of this medication. The guidelines do not support gabapentin in this case. The request for 600mg 1/2 HS #30 **is not medically necessary and appropriate.**

3) Regarding the request for hydrocodone Bit/PAPA tid #90:

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), pgs. 75 and 89, part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, (2009), On-Going Management, pg. 78, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 12/30/09 the employee sustained a work-related injury. The submitted and reviewed medical records document constant low back pain with radiation to the bilateral lower extremities to the level of the toes, with numbness and tingling. Treatment has included: medications, physical therapy, TENS unit, chiropractic care, right shoulder injection, and lumbar epidural steroid injection. The records indicate diagnoses of lumbar radiculitis, depression, anxiety, right shoulder pain, right hand pain, chronic pain trauma, right index finger and middle finger PIP level amputation, right thumb amputation through distal phalanx, right ring finger

distal tuft fracture with nail bed injury, history of gastric ulcers, and erectile dysfunction. A request has been submitted for hydrocodone Bit/PAPA tid #90.

MTUS Chronic Pain Guidelines note that analgesia, activities of daily living, adverse side effects and aberrant drug-related behaviors are the most relevant domains for ongoing monitoring of chronic pain patients on opioids. A reviewed drug screen dated 7/18/13 indicates possible aberrant behavior; however, the records do not indicate this was addressed with the employee. The guidelines do not support this medication in this case. The requested hydrocodone Bit/PAPA tid #90 **is not medically necessary and appropriate.**

4) Regarding the request for tramadol ER 150mg QD #30:

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), Opioids for neuropathic pain, pg. 82 and Tramadol, pg. 93, part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, (2009), Tramadol, pg. 93 and 113, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 12/30/09 the employee sustained a work-related injury. The submitted and reviewed medical records document constant low back pain with radiation to the bilateral lower extremities to the level of the toes, with numbness and tingling. Treatment has included: medications, physical therapy, TENS unit, chiropractic care, right shoulder injection, and lumbar epidural steroid injection. The records indicate diagnoses of lumbar radiculitis, depression, anxiety, right shoulder pain, right hand pain, chronic pain trauma, right index finger and middle finger PIP level amputation, right thumb amputation through distal phalanx, right ring finger distal tuft fracture with nail bed injury, history of gastric ulcers, and erectile dysfunction. A request has been submitted for tramadol ER 150mg QD #30.

MTUS Chronic Pain Guidelines indicate tramadol is a synthetic opioid affecting the central nervous system, and this medication is not recommended as a first-line oral analgesic. The guidelines state that ongoing management of opioids must include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The submitted medical records indicate that the employee has been on this medication for a significant length of time. However, a drug panel dated 7/18/13 revealed test results were not consistent with the prescribed medications and there was no documentation stating this was addressed with the employee. The request for tramadol ER 150mg QD #30 **is not medically necessary and appropriate.**

5) Regarding the request for Exoten-C lotion:

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

The Claims Administrator based its decision on the Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guidelines, (2009), pages 111-113, part of the Medical Treatment Utilization 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:

On 12/30/09 the employee sustained a work-related injury. The submitted and reviewed medical records document constant low back pain with radiation to the bilateral lower extremities to the level of the toes, with numbness and tingling. Treatment has included: medications, physical therapy, TENS unit, chiropractic care, right shoulder injection, and lumbar epidural steroid injection. The records indicate diagnoses of lumbar radiculitis, depression, anxiety, right shoulder pain, right hand pain, chronic pain trauma, right index finger and middle finger PIP level amputation, right thumb amputation through distal phalanx, right ring finger distal tuft fracture with nail bed injury, history of gastric ulcers, and erectile dysfunction. A request has been submitted for Exoten-C lotion.

MTUS Chronic Pain Guidelines state that topical medications are largely experimental in use with few randomized controlled trials to determine efficacy and safety of this type of medication. Exoten-C lotion is a compounded topical medication that includes the medication capsaicin. The guidelines note that if one medication in a topical compound is not recommended then the topical medication is not recommended. Per the guidelines, Capsaicin is recommended as an option in patients who have not responded or are intolerant of other treatments. The medical records reviewed do not indicate that other treatment options were tried and failed. The guidelines do not support Exoten-C in this case. The request for Exoten-C **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

/srb

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.