

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/23/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/11/2013
Date of Injury: 8/18/2000
IMR Application Received: 7/22/2013
MAXIMUS Case Number: CM13-0002563

- 1) MAXIMUS Federal Services, Inc. has determined the lumbar corset quantity 1 requested **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the LSO back brace quantity 1 requested **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the ten (10) sessions of chiropractic treatment for the lumbar spine requested **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the Xoten-c lotion 0.002%/10%/20%, 120 ml quantity 120 requested **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the Tizanidine 4 mg, #120 requested **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the Tramadol ER 150 mg, #60 requested **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the Omeprazole 20 mg, #100 requested **is not medically necessary and appropriate.**

- 8) MAXIMUS Federal Services, Inc. has determined the Zolpidem 10 mg, #30 requested **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 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 lumbar corset quantity 1 requested **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the LSO back brace quantity 1 requested **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the ten (10) sessions of chiropractic treatment for the lumbar spine requested **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the Xoten-c lotion 0.002%/10%/20%, 120 ml quantity 120 requested **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the Tizanidine 4 mg, #120 requested **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the Tramadol ER 150 mg, #60 requested **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the Omeprazole 20 mg, #100 requested **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the Zolpidem 10 mg, #30 requested **is not medically necessary and appropriate.**

Medical Qualifications of the Professional 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 professional 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 11, 2013:

“This 76 year old female has a date of injury on 8/18/2000 for an industrial injury sustained with [REDACTED]. The accepted body parts for this

claim are the lumbar spine and bilateral wrists. The patient was previously declared Permanent & Stationary.

Orthopedic reevaluation by Dr. [REDACTED] on 6/18/13 reported a subjective complaint of a significant increase in low back pain. Lumbar exam documented gait with a limp, restricted flexion and extension, muscle tenderness and spasm, and decreased sensation in the L5 dermatome bilaterally. Diagnoses were status post bilateral carpal tunnel release surgery, lumbar stenosis, and bilateral ankle synovitis.”

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 (Dated 7/22/2013)
- Utilization Review Determination from [REDACTED] (Dated 9/11/2013)
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for lumbar corset quantity 1 :

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Low Back Complaints, pg. 308, part of the MTUS. 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 8/18/00. The submitted medical records indicate that the employee’s accepted body parts are the lumbar spine and bilateral wrists. The employee’s diagnoses include right wrist pain following carpal tunnel release, left wrist pain status post carpal tunnel release, lumbar stenosis, and bilateral ankle synovitis. The records indicate the patient was having an acute exacerbation of back pain, for which an intramuscular injection was given in an attempt to alleviate pain. A request has been submitted for lumbar corset quantity 1.

MTUS ACOEM guidelines note that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The medical records provided indicate that the employee’s date of injury was over 13 years ago. The records indicate the employee has had a recent exacerbation of lumbar pain; however, the request for a low back brace and lumbar corset as part of the conservative treatment regimen is outside the initial acute phase of injury and not supported by the guidelines. The request for a lumbar corset quantity 1 **is not medically necessary and appropriate.**

2) Regarding the request for LSO back brace quantity 1 :

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

The Claims Administrator based its decision on American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Low Back Complaints, pg. 308, part of the MTUS. 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 8/18/00. The submitted medical records indicate that the employee's accepted body parts are the lumbar spine and bilateral wrists. The employee's diagnoses include right wrist pain following carpal tunnel release, left wrist pain status post carpal tunnel release, lumbar stenosis, and bilateral ankle synovitis. The records indicate the patient was having an acute exacerbation of back pain, for which an intramuscular injection was given in an attempt to alleviate pain. A request has been submitted for LSO back brace quantity 1.

MTUS ACOEM guidelines note that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The medical records provided indicate that the employee's date of injury was over 13 years ago. The records indicate the employee has had a recent exacerbation of lumbar pain; however, the request for a low back brace and lumbar corset as part of the conservative treatment regimen is outside the initial acute phase of injury and not supported by the guidelines. The request for LSO back brace quantity 1 **is not medically necessary and appropriate.**

3) Regarding the request for 10 sessions of ten (10) sessions of chiropractic treatment for the lumbar spine :

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

The Claims Administrator based its decision on Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation, pg. 58, part of the MTUS. 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 8/18/00. The submitted medical records indicate that the employee's accepted body parts are the lumbar spine and bilateral wrists. The employee's diagnoses include right wrist pain following carpal tunnel release, left wrist pain status post carpal tunnel release, lumbar stenosis, and bilateral ankle synovitis. The records indicate the patient was having an acute exacerbation of back pain, for which an intramuscular injection was given in an attempt to alleviate pain. A request has been submitted for chiropractic treatment for ten sessions for the lumbar spine .

MTUS Chronic Pain guidelines note that chiropractic treatment/manual therapy may be indicated initially for the lumbar spine in a trial of 6 visits over 2 weeks. For recurrences and flare-ups, there is a need to reevaluate treatment success and if the patient has returned to work, then 1 to 2 visits every 4 to 6 months may be warranted. The current request for 10 sessions for treatment of the lumbar spine is in excess of guidelines recommendations. The request for ten sessions of chiropractic treatment for the lumbar spine **is not medically necessary and appropriate.**

4) Regarding the request for Xoten-c lotion 0.002%/10%/20%, 120 ml quantity 120 :

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg. 112, part of the MTUS. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg. 105-113, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 8/18/00. The submitted medical records indicate that the employee's accepted body parts are the lumbar spine and bilateral wrists. The employee's diagnoses include right wrist pain following carpal tunnel release, left wrist pain status post carpal tunnel release, lumbar stenosis, and bilateral ankle synovitis. The records indicate the patient was having an acute exacerbation of back pain, for which an intramuscular injection was given in an attempt to alleviate pain. A request has been submitted for Xoten-c lotion 0.002%/10%/20%, 120 ml quantity 120.

Xoten-c lotion contains capsaicin and methyl salicylate. MTUS Chronic Pain guidelines note that topical analgesics are largely experimental due to few randomized controlled trials to determine their efficacy or safety. The guidelines recommend topical salicylate for chronic pain; however, there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that an increase over a 0.025% formulation would provide any further efficacy. The guidelines do not support for a formulation inclusive of 20% capsaicin. The requested Xoten-c lotion 0.002%/10%/20%, 120 ml quantity 120 **is not medically necessary and appropriate.**

5) Regarding the request for Tizanidine 4 mg, #120 :

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Muscle Relaxants for Pain, pg. 63, part of the MTUS. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Muscle Relaxants for Pain, pg. 63 and Antispasticity/Antispasmodic Drugs, pg. 66, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 8/18/00. The submitted medical records indicate that the employee's accepted body parts are the lumbar spine and bilateral wrists. The employee's diagnoses include right wrist pain following carpal tunnel release, left wrist pain status post carpal tunnel release, lumbar stenosis, and bilateral ankle synovitis. The records indicate the patient was having an acute exacerbation of back pain, for which an intramuscular injection was given in an attempt to alleviate pain. A request has been submitted for Tizanidine 4 mg, #120 .

The MTUS Chronic Pain guidelines indicate that antispasticity/antispasmodic drugs such as Tizanidine are FDA approved for the management of spasticity with unlabeled use for low back pain. Furthermore, the guidelines indicate that studies have demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and it is recommended as a first-line option to treat myofascial pain. The records provided indicate that the employee has evidence on physical examination of decreased range of motion with evidence of paraspinal muscle tenderness, muscle spasm, and guarding, for which the use of Tizanidine would be warranted. However, the records note the employee to have been prescribed this medication on two other occasions with no clear indication of the response to this medication. Furthermore, the guidelines do not support the long-term use of the medication. The requested Tizanidine 4 mg, #120 **is not medically necessary and appropriate.**

6) Regarding the request for Tramadol ER 150 mg, #60 :

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use, pg. 80, part of the MTUS. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Opioids, pg. 78, 93-94, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 8/18/00. The submitted medical records indicate that the employee's accepted body parts are the lumbar spine and bilateral wrists. The employee's diagnoses include right wrist pain following carpal tunnel release, left wrist pain status post carpal tunnel release, lumbar stenosis, and bilateral ankle synovitis. The records indicate the patient was having an acute exacerbation of back pain, for which an intramuscular injection was given in an attempt to alleviate pain. A request has been submitted for Tramadol ER 150 mg, #60.

The MTUS Chronic Pain guidelines note that Tramadol is a synthetic opioid affecting the central nervous system and is indicated for moderate to severe pain. The records indicate the employee had a severe exacerbation of low back symptoms. The guidelines appear to support the request for Tramadol in this instance; however, there is indication in the documentation that the employee

has been on this medication for an extended period. The guidelines indicate the 4 A's for ongoing monitoring of patient's on opioid analgesics. These domains are recommended as consideration for analgesia, activities of daily living, adverse side effects and abhorrent drug related behaviors. There is no indication in the notes regarding effective analgesia from this long term medication and no indication of improvement in the employee's ability to undertake activities of daily living. The requested Tramadol ER 150 mg, #60 **is not medically necessary and appropriate.**

7) Regarding the request for Omeprazole 20 mg, #100 :

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI Symptoms and Cardiovascular Risk, pg. 68, which is part of the MTUS. 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 8/18/00. The submitted medical records indicate that the employee's accepted body parts are the lumbar spine and bilateral wrists. The employee's diagnoses include right wrist pain following carpal tunnel release, left wrist pain status post carpal tunnel release, lumbar stenosis, and bilateral ankle synovitis. The records indicate the patient was having an acute exacerbation of back pain, for which an intramuscular injection was given in an attempt to alleviate pain. A request has been submitted for Omeprazole 20 mg, #100 .

The MTUS Chronic Pain guidelines note that proton pump inhibitors such as Omeprazole may be indicated for patients at intermediate risk for gastrointestinal events. However, the documentation submitted for review fails to detail current gastrointestinal symptoms to support the prescription of Omeprazole. The efficacy of this medication was not documented to support continued use. The requested Omeprazole 20 mg, #100 **is not medically necessary and appropriate.**

8) Regarding the request for Zolpidem 10 mg, #30:

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

The Claims Administrator based its decision on Official Disability Guidelines, Pain, Zolpidem (Ambien). The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. 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 8/18/00. The submitted medical records indicate that the employee's accepted body parts are the lumbar spine and bilateral wrists. The employee's diagnoses include right wrist pain following carpal tunnel release, left wrist pain status post carpal tunnel release, lumbar stenosis, and bilateral ankle synovitis. The records indicate the patient was having an acute exacerbation of back pain, for which an intramuscular injection was given in an attempt to alleviate pain. A request has been submitted for Zolpidem 10 mg, #30.

Official Disability Guidelines note that Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic which is approved for the short-term, usually 2 to 6 weeks for treatment of insomnia. The requested medication is not recommended for long-term use. In this case, there is a lack of documentation indicating the length of time for which the employee was prescribed the medication. The requested Zolpidem 10 mg, #30 **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.