

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/22/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/12/2013
Date of Injury: 10/23/2008
IMR Application Received: 7/24/2013
MAXIMUS Case Number: CM13-0003012

- 1) MAXIMUS Federal Services, Inc. has determined the request for X-Force stimulator unit with supplies **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Solar Care FIR heating system **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for topical compound of Gaba, Keto, Tramadol **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20MG **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Tramadol 150MG **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Xanax 1MG **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 X-Force stimulator unit with supplies **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Solar Care FIR heating system **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for topical compound of Gaba, Keto, Tramadol **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20MG **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Tramadol 150MG **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Xanax 1MG **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 12, 2013:

“The patient is a 50 year old male with a date of injury of 10/23/2008. The prospective request is for 1 X-Force stimulator unit with supplies, 1 Solar Care FIR heating system, 1 prescription topical compound 07/10/2013 to request the following information: Please indicate how long the patient has been using the medications tramadol and Xanax, the medical rationale supporting their continued use, and quantified subjective and objective findings of the patient's response while using the medications vs, when he is not, Include any functional improvements made while taking the medications (ADL's, walking,

sleep, etc.). Provide the patient's indications or diagnosis for use of Prilosec. Include the specific dosage and quantity pertaining to all of these requested medications.

At this time, the requested information has not been received, and the reviewer therefore recommends that the request for I prescription of Prilosec 20mg be conditionally non-certified. Please note that this outcome represents an administrative action taken to comply with regulatory time frame constraints, and does not represent a denial based on medical necessity. The request will be reconsidered upon receipt of the information requested.”

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 07/24/2013)
- Utilization Review Determination from [REDACTED] (dated 07/12/2013)
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for X-Force stimulator unit with supplies :

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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004), Low back complaints, pg 162, which is part of the MTUS. The Expert Reviewer found the referenced criteria 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 10/23/08. The submitted medical records noted neck pain, low back pain and left shoulder pain. The employee’s diagnoses include status post left rotator cuff repair of the massive tear and partial distal claviclectomy, anxiety, depression, insomnia, resolved cervical sprain, and resolved lumbar sprain. The submitted medical records note that prior treatment has included medications. A request has been submitted for X-Force stimulator unit with supplies.

The MTUS ACOEM guidelines note that transcutaneous electrical nerve stimulation is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. In this case, the submitted medical records do not include a rationale for this device. There was no trial period, and there is no mention that the passive modality will be used as an adjunct to a program of functional restoration. The requested X-Force stimulator unit with supplies **is not medically necessary and appropriate.**

2) Regarding the request for Solar Care FIR heating system :

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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004), Shoulder complaints, pg. 203 which is part of MTUS. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Physical Medicine, pg. 98-99, 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 10/23/08. The submitted medical records noted neck pain, low back pain and left shoulder pain. The employee's diagnoses include status post left rotator cuff repair of the massive tear and partial distal claviclectomy, anxiety, depression, insomnia, resolved cervical sprain, and resolved lumbar sprain. The submitted medical records note that prior treatment has included medications. A request has been submitted for Solar Care FIR heating system .

The MTUS Chronic Pain guidelines do not recommend passive therapy or treatment modalities in the late phases of treatment. The submitted medical records do not discuss a rationale for requesting the passive modality for Solar Care FIR heating system at this point in time. The requested Solar FIR heating system **is not medically necessary and appropriate.**

3) Regarding the request for topical compound of Gaba, Keto, Tramadol :

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 found the Chronic Pain Medical Treatment Guidelines, (2009), Topical Analgesics, pg. 111-113, which is 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 10/23/08. The submitted medical records noted neck pain, low back pain and left shoulder pain. The employee's diagnoses include status post left rotator cuff repair of the massive tear and partial distal claviclectomy, anxiety, depression, insomnia, resolved cervical sprain, and resolved lumbar sprain. The submitted medical records note that prior treatment has included medications. A request has been submitted for topical compound of Gaba, Keto, Tramadol .

The MTUS Chronic Pain guidelines note that a compounded topical cream is not recommended if one component is not recommended. In this case, the guidelines do not recommend Ketoprofen as a topical agent. Additionally, the guidelines do not recommend Tramadol for over three months. The requested topical compound of Gaba, Keto, Tramadol **is not medically necessary and appropriate.**

4) Regarding the request for Prilosec 20MG :

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 found the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, pg. 68-69, which is 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 10/23/08. The submitted medical records noted neck pain, low back pain and left shoulder pain. The employee's diagnoses include status post left rotator cuff repair of the massive tear and partial distal claviclectomy, anxiety, depression, insomnia, resolved cervical sprain, and resolved lumbar sprain. The submitted medical records note that prior treatment has included medications. A request has been submitted for Prilosec 20mg.

The MTUS Chronic Pain guidelines note that clinicians should weigh the indications for NSAIDs against both gastrointestinal and cardiovascular risk factors. The submitted medical records note that the employee was using Prilosec on 12/17/12. However, there are no gastrointestinal risk factors or mention of NSAIDs causing dyspepsia to support the use of Prilosec in the available records from 12/17/12 through 6/25/13. The requested Prilosec 20mg **is not medically necessary and appropriate.**

5) Regarding the request for Tramadol 150MG :

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 provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Tramadol, pg. 93-94, which is 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 10/23/08. The submitted medical records noted neck pain, low back pain and left shoulder pain. The employee's diagnoses include status post left rotator cuff repair of the massive tear and partial distal claviclectomy, anxiety, depression, insomnia, resolved cervical sprain, and resolved lumbar sprain. The submitted medical records note that prior treatment has included medications. A request has been submitted for Tramadol 150MG.

The MTUS Chronic Pain guidelines do not recommend the use of Tramadol for over three months. The records indicate the use of Tramadol for over 6 months. This is not in accordance with guideline recommendations. The requested Tramadol 150MG **is not medically necessary and appropriate.**

6) Regarding the request for Xanax 1MG :

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 found the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, pg. 24, which is 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 10/23/08. The submitted medical records noted neck pain, low back pain and left shoulder pain. The employee's diagnoses include status post left rotator cuff repair of the massive tear and partial distal claviclectomy, anxiety, depression, insomnia, resolved cervical sprain, and resolved lumbar sprain. The submitted medical records note that prior treatment has included medications. A request has been submitted for Xanax 1MG .

The MTUS Chronic Pain guidelines do not recommend use of benzodiazepines for over four weeks. The submitted medical records show ongoing prescriptions for six months. This is not in accordance with guideline recommendations. The requested Xanax 1MG **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.