

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 10/29/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/23/2013
Date of Injury:	2/3/2005
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0003832

- 1) MAXIMUS Federal Services, Inc. has determined the request for a pain management interdisciplinary evaluation for the lower back **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. 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 a pain management interdisciplinary evaluation for the lower back **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 Orthopedic 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 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.

Expert Reviewer Case Summary:

The patient is a 58-year-old male who reported a work related injury to his lumbar spine and cervical spine on 02/03/2005; specific mechanism of injury was not stated. The patient presents with treatment for the following diagnoses: cervical spondylosis with chronic intractable pain, lumbar spondylosis with chronic intractable pain, grade I spondylolisthesis L5-S1, chronic pain syndrome, status post L5-S1 fusion with laminectomy and foraminectomy, postlaminectomy syndrome, repeat lumbar fusion from L4-S1, and probable cervical radiculopathy of the upper extremities. Clinical note dated 06/03/2013 reports the patient was evaluated under the care of Dr. [REDACTED] for his chronic pain complaints. The provider documented the patient utilizes Nucynta ER 200 mg 1 tab by mouth 2 times a day, Nucynta 100 mg 1 tablet to 2 tablets by mouth 2 times a day, Norco 10/325 one tablet 3 times a day, tramadol 50 mg 1 tablet 4 times a day, Valium 10 mg 1 tablet 2 times a day, Treximet 85/500 one tablet, and ibuprofen 800 mg 1 tablet 3 times a day for his pain complaints. The provider documents the patient's course of treatment since status post his sustained work related injury, which included injection therapy, chiropractic treatment, pain medication, physical therapy, and massage therapy, which resulted in no resolve of his symptomatology. The provider documented the patient had a prior history of a fusion, laminectomy, and foraminotomy at the L5-S1 as of 06/1985. The patient did have to undergo a repeat lumbar fusion at the L4-S1 with hardware placement as of 01/2006. The provider documented physical exam findings of the patient revealed range of motion of the bilateral upper extremities evidenced right shoulder flexion to 160 degrees and left shoulder flexion to 180 degrees; however, pain was elicited. The patient had 2/4 reflexes noted to the bilateral lower extremities. Straight leg raise on the left was positive at 40 degrees. The patient's motor strength throughout the bilateral upper and lower extremities was evidenced to be between 3-4/5. The provider documented the patient had tenderness throughout the cervical and lumbar spines with palpation, eliciting pain complaints. The provider recommended the patient utilize chronic pain management program.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for pain management interdisciplinary evaluation for the lower back :

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, page 49, part of the MTUS. The Expert Reviewer found the Cornerstones of Disability Prevention and Management (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 5), pages 89-92, part of the MTUS and the Chronic Pain Medical Treatment Guidelines, Criteria for the general use of multidisciplinary pain management programs, pages 31-32, part of the MTUS relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

California MTUS guidelines note, "Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." The notes indicate the employee has attended two previous chronic pain/functional restoration programs with lack of resolve of subjective or objective symptomatology and continues to utilize chronic opioids in excess of recommended guidelines. Therefore, the request for a pain management interdisciplinary evaluation for lower back **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

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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.