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**Notice of Independent Medical Review Determination**

Dated: 11/25/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	3/7/2005
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004118

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #180 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Valium 5mg #30 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20mg #30 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **peripheral nerve stimulator is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **1 bilateral L1-2 transforaminal epidural steroid injection is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **1 facet injection bilateral L4-5 and L5-S1 is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **1 vital wrap system is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/9/2013. 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 **Norco 10/325mg #180 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Valium 5mg #30 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20mg #30 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **peripheral nerve stimulator is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **1 bilateral L1-2 transforaminal epidural steroid injection is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **1 facet injection bilateral L4-5 and L5-S1 is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **1 vital wrap system 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 Preventive Medicine and Occupational Medicine, 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 applicant, Mr. [REDACTED] is a represented former plumber with extensive periods of time off of work. He is a 44-year-old, who has filed a claim for chronic low back pain, reportedly associated with an industrial injury of March 7, 2005.

Thus far, he has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; three prior lumbar spine surgeries; spinal cord stimulator implantation; an unspecified amounts of physical therapy over the life of the claim; an electrodiagnostic testing of November 29, 2012, notable for chronic L4-L5 radiculopathy; and extensive periods of time off of work.

A recent report of June 11, 2013 is notable for comments that the applicant reports persistent 8/10 pain, with numbness about the left lower extremity. He is reportedly disabled. He states that his pain has been diminished by about 50%, as a result of the spinal cord stimulator. It is stated in one section of the report that the applicant has limited usage of OxyContin. The applicant is having issues with urinary incontinence and bowel incontinence, as well as erectile dysfunction. He apparently has undergone a recent CT myelogram, the results of which have not been stated. He is presently on Norco, Zanaflex, Prilosec, and Valium. The spinal cord stimulator site is well healed. The applicant exhibits an antalgic gait with multiple trigger points. He has difficulty standing and exhibits diminished lumbar range of motion. Lower extremity strength and sensation are diminished. Recommendations are made for the applicant to continue Norco, Valium, Prilosec, and physical therapy while obtaining an epidural steroid injection. Facet injections are also sought.

### **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 [REDACTED]
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for Norco 10/325mg #180:**

##### 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 based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 80, which is part of the MTUS.

Rationale for the Decision:

As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, primary criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain. In this case, the limited documentation on file does not establish the presence of any of the aforementioned criteria. The employee has failed to return to work. There is no seeming evidence of improved functioning and/or reduced pain. The employee's pain has reportedly worsened and functioning has seemingly deteriorated over time. **The request for Norco 10/325mg #180 is not medically necessary and appropriate.**

**2) Regarding the request for Valium 5mg #30:**

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 based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, pg. 24, which is part of the MTUS.

Rationale for the Decision:

As noted on page 24 of the MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use purposes either in the treatment of anxiety, depression, chronic pain, or as an anticonvulsants. In this case, moreover, it appears that employee has used this particularly agent chronically. There is no evidence of functional improvement as defined in section 9792.20f in terms of work status, work restrictions, activities of daily living, and/or diminished reliance on medical treatment. The employee is seemingly highly reliant on various medical treatments and medications, and the ability to perform activities of daily living has seemingly deteriorated over time. The employee has failed to return to work. Therefore, there is no evidence of functional improvement which might make a case for a variance from the guidelines. **The request for Valium 5mg #30 is not medically necessary and appropriate.**

**3) Regarding the request for Prilosec 20mg #30:**

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 based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 69, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that proton-pump inhibitor such as Prilosec are indicated in the treatment of dyspepsia or reflux. According to the medical records provided for review documentation on file does not establish the presence of issues with dyspepsia, either NSAID induced or standalone. **The request for Prilosec 20mg #30 is not medically necessary and appropriate.**

**4) Regarding the request for peripheral nerve stimulator:**

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

The Claims Administrator based it's decision on the National Guidelines Clearinghouse, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Percutaneous electrical nerve stimulation (PENS), pg. 97, which is part of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that percutaneous electrical nerve stimulation is not certified as the primary treatment modality. It may be considered on a trial basis if employed to as adjunct to a program of functional restoration in those individuals who have failed other non-surgical treatments, including home exercise and a TENS unit. According to the medical records provided for review, there is no clear evidence that the employee has failed a TENS unit. **The request for peripheral nerve stimulator is not medically necessary and appropriate.**

**5) Regarding the request for 1 bilateral L1-2 transforaminal epidural steroid injection:**

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 based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 46, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate the purpose of epidural steroid injections is to reduce pain and inflammation and avoid surgery. In this case, however, a neurosurgery consultation has been sought concurrently. It is suggested that the employee's bowel and bladder incontinence will likely warrant neurosurgical intervention, obviating the need for epidural steroid injection therapy. It is further noted that employee underwent recent CT myelography, the results of which are unknown. Thus, there does not appear to be any active radiographic corroboration for the employee's radicular complaints. The electrodiagnostic evidence of chronic radiculopathy is of lesser import at this point in time and does not make a compelling case for an epidural steroid injection when it appears that the employee is, in fact, considering surgical remedy. **The request for 1 bilateral L1-2 transforaminal epidural steroid injection is not medically necessary and appropriate.**

**6) Regarding the request for 1 facet injection bilateral L4-5 and L5-S1:**

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

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Low Back Complaints, Chapter 12, which is part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines indicate that there is a lack of quality medical literature supporting facet joint infections in the lumbar region. According to the medical records provided for review the fact that epidural steroid injections, facet injections and neurosurgery consultations have been sought in parallel suggests a lack of diagnostic clarity. Therefore, the proposed facet injections are non-certified, both owing to lack of diagnostic clarity and owing to the unfavorable ACOEM recommendation. **The request for 1 facet injection bilateral L4-5 and L5-S1 is not medically necessary and appropriate.**

**7) Regarding the request for 1 vital wrap system:**

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

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, Low Back Complaints, Chapter 12, which is part of the MTUS, and ACOEM 3rd edition, Chronic Pain, General Principles of Treatment.

Rationale for the Decision:

ACOEM Guidelines indicate that high-tech applications of heat and cold are not recommended in the treatment of any chronic pain conditions as these are considered items that applicant can perform independently. This is echoed by the MTUS-adopted ACOEM guidelines in chapter 12, which suggest that at-home local applications of heat and cold are as effective as those performed by therapist or, by extension, by high-tech means. Based on the product description, the VitalWrap System appears to represent high-tech means of delivering a hot and cold therapy. **The request for 1 vital wrap system 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,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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Oakland, CA 94612

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