
Notice of Independent Medical Review Determination

Dated: 11/8/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/19/2013
Date of Injury: 4/13/2005
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0007327

- 1) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy for the lumbar spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Voltaren gel 1% tube is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **outpatient detox is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **lab test: testosterone level is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **massage is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **B12 1000mcg is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/5/2013. 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 **physical therapy for the lumbar spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Voltaren gel 1% tube is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **outpatient detox is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **lab test: testosterone level is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **massage is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **B12 1000mcg 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.

Expert Reviewer Case Summary:

The patient is a 57-year-old male who reported an injury on 04/13/2005. An MRI of the lumbar spine with and without contrast performed on 05/22/2013 reported an impression of status post posterior decompression with anterior and posterior fusion at L5-S1 with no residual recurrent canal or neural foraminal compromise seen. Clinical note dated 06/03/2013, signed by Dr. [REDACTED], reported the patient is reported to have increasing pain and Dr. [REDACTED] was out of town, he was covering for the patient. The patient is noted to have had increasing pain and he had received a prescription for 360 oxycodone, which would allow for 40 mg increase a day in the oxycodone, which was anticipated to last for a month at an average of 12 a day. He presented 3 weeks later with a prescription from Dr. [REDACTED] that would be 1 week early and Dr. [REDACTED] had a maximum of 10 a day. Dr. [REDACTED] reviewed his case and current medication use and the fact that other agents were needed to be tried to get a better control of his deep neuropathic pain, which was anticipated to reduce his opiate use. On physical exam,

the patient is noted to have tightness in her upper back and neck. He was able to forward flex and touch his knees, straight leg raising gave him pulling in the back and down his legs. He stood and walked with a slightly guarded gait. The patient is noted to have undergone a left hip replacement x2, to have been diagnosed with a right hip sprain, and to have undergone a lumbar decompression on an unstated date, followed by a 360 degree lumbar fusion. X-rays of the pelvis and hip performed on 06/24/2013, read by Dr. [REDACTED] reported an impression of post left total hip replacement with no apparent complication, anterior and posterior fusion at L5-S1. On 07/01/2013, the patient was seen by E. Redick, PA, and reported the patient complained of progressive worsening pain rated 9/10 with ongoing pain in the mid-lower back and was having to take more oxycodone 50 mg 3 times daily up from 30 mg 3 times a day and OxyContin 40 mg 2 daily. He reported he could not function at normal level now, without increased opioids. The pain was peri-incisional radiating to the left buttock, left posterior thigh and anterior thigh, and right axial pain was also present with burning. On physical examination, the patient is noted to have positive lumbar facet loading on both sides, straight leg raising test positive on the left side, and tenderness over the coccyx. He had 4-5/ strength of the left quadriceps in extension, and decreased sensation to light touch in the lateral calf and anterior calf. The patient is noted to have undergone bilateral L3, L4, and L5 medial branch blocks on 08/10/2013. On 08/07/2013, the patient was seen by Dr. [REDACTED], who reported the patient had progressively worsened pain rated 8/10 to 9/10. He reported he had medial branch blocks done with 50% relief and took 50% less opioids during that time. However, the pain had returned when he tried to go camping. The patient was noted to be taking oxycodone 50 mg 4 times daily. A Letter of Determination from EK Health dated 07/19/2013 non-certified the request for physical therapy for the lumbar spine, Voltaren gel 1% tube, urgent outpatient detox, lab tests for testosterone levels, massage, and B12 injection. A Letter of Determination from Bunch Care Solutions dated 08/21/2013 again non-certified the request for in-office detox for 5 days and massage therapy and physical therapy 1 time a week for 4 weeks, along with right and left L3, L4, and L5 radiofrequency ablation.

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 physical therapy for the lumbar spine:

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, Physical Medicine, page 98-99, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, pages 98-99, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines recommend up to 9 to 10 visits over 8 weeks for myalgia or myositis and 8 to 10 visits over 4 weeks for neuralgia or neuritis or radiculitis. The guidelines also indicate that there must be documentation of functional improvement from prior treatment which means either a clinically significant improvement in activities of daily living or a reduction of work restrictions and a reduction in dependence on continued medical treatment. The medical records provided for review do not provide documentation of the number of previous physical therapy sessions the employee attended or the dates, nor is there documentation that the employee had significant clinical improvement with use of previous physical therapy, or that the employee is using a home exercise program to continue to obtain improvements from previous physical therapy.

The request for physical therapy for the lumbar spine is not medically necessary and appropriate.

2) Regarding the request for Voltaren gel 1% tube:

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, Topical Analgesics, pages 111-113, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-112, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that the use of topical non-steroidal anti-inflammatories for treatment of osteoarthritis or tendinitis and note that Voltaren gel is indicated for the relief of osteoarthritic pain in the joints that lend themselves to topical treatment such as the ankle, elbow, foot, knee, hand, and wrist. The medical records provided for review indicate that the employee is reported to complain of low back pain and not being treated for osteoarthritis pain in joints. The request does not meet guideline recommendations. **The request for Voltaren gel 1% tube is not medically necessary and appropriate.**

3) Regarding the request for outpatient detox:

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, pages 78-80, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Rapid detox, pages 102-103, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines do not recommend rapid detox stating that gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. The data supporting the safety and effectiveness of opioid antagonistic agent detoxification under sedation or general anesthesia is limited and adequate safety has not been established. As such, the request for outpatient detox over 5 days does not meet guideline recommendations. **The request for outpatient detox is not medically necessary and appropriate.**

4) Regarding the request for lab test: testosterone level:

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, pages 110-111, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Testosterone replacement for hypogonadism (related to opioids), page 110, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that testosterone replacement is recommended for hypogonadism related to opioids in limited circumstances for patients taking high dose long-term opioids with documented testosterone level, but state that routine testing of testosterone levels in patients taking opioids is not recommended unless they exhibit signs of hypogonadism such as gynecomastia. The medical records provided for review do not indicate that the employee has demonstrated signs or symptoms of hypogonadism on physical exam; however, the requested lab test for testosterone levels does not meet guideline recommendations. **The request for lab test: testosterone level is not medically necessary and appropriate.**

5) Regarding the request for massage:

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, Massage Therapy, page 60, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Massage therapy, page 60, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines recommend the use of massage therapy as an adjunct to other recommended treatment such as exercises and should be

limited to 4 to 6 visits. The medical records provided for review do not indicate that the employee has previously undergone massage therapy with documentation of functional improvement or decrease in medication use. **The request for massage is not medically necessary and appropriate.**

6) Regarding the request for B12 1000mcg:

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 Official Medical Fee Schedule (OMFS), page 7, which is not part of the MTUS. The Claims Administrator also cited the Official Disability Guidelines (ODG), Pain Chapter, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Online Version, Pain (Chronic) Chapter.

Rationale for the Decision:

The Official Disability Guidelines indicate that vitamin B is not recommended. The requested B12 injection does not meet guideline recommendations. Vitamin B is frequently used to treat peripheral neuropathy, but its effectiveness is not clear. Recent analysis concluded that the evidence was insufficient to determine whether vitamin B was beneficial or harmful. **The request for B12 1000mcg 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
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.