
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/26/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/6/2013
Date of Injury: 10/16/2000
IMR Application Received: 8/20/2013
MAXIMUS Case Number: CM13-0014090

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 10/16/2000. Treating diagnoses include lumbar radiculitis, cervical radiculitis, headaches, depression, gastritis, NSAID intolerance, intolerance of multiple opioids, status post right shoulder surgery x3, history of incontinence, and xerostomia. The treating provider has submitted a utilization review appeal as well as a pain medicine reevaluation note on 8/26/2013. At that time the provider noted that the patient complained of low back pain radiating to both lower extremities as well as neck pain radiating to both upper extremities. The patient reported limitations in self-care/hygiene, activity, ambulation, hand function, sleep, and sexual function. The patient reported that he tolerated Celebrex, but not other antiinflammatory medications. On examination the patient had an antalgic gait assisted with the use of a cane. The patient had moderate reduction of lumbar motion due to pain, particularly with flexion or extension. Spinal tenderness was noted to palpation at L4 through S1. There were no changes in the motor or sensory examination. The treating provider recommended a treatment program including an appeal of aquatic therapy, noting that the patient had better benefit in the past compared to land therapy. The provider also refilled Celebrex as well as Neurontin for chronic neuropathic pain. The provider also recommended omeprazole given gastrointestinal effects of nonsteroidal antiinflammatory medications. The patient also recommended Ultram as a nonopioid analgesic prescribed for pain.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Celebrex 200mg #60 is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), which are part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 22, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on antiinflammatory medications states "Cox-2 inhibitors e.g. Celebrex, may be considered if the patient has a risk of gastrointestinal complications but not for the majority of patients . . . Anti-inflammatories are the traditional first-line of treatment to reduce pain so activity and functional restoration can resume." The medical records in this case do clearly outline a history of gastrointestinal intolerance from traditional antiinflammatory medications. Therefore, Celebrex would be supported by the guidelines as a first-line medication in this patient with multiple forms of musculoskeletal pain. Therefore, this request is medically necessary.

2. Neurontin 300mg #90 is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), which are part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 18, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on antiepileptic medications states regarding Neurontin "Has been considered as a first-line treatment for neuropathic pain." The medical records in this case do clearly document neuropathic pain from cervical and lumbar radiculitis. This medication is a first-line medication in that situation and the records document the patient reports improvement from this medication. Therefore, this treatment is medically necessary.

3. Ultram 50mg #120 is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), which are part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 113, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Tramadol states that Ultram "Is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic." The treating physician notes state that this medication is a nonopioid analgesic, which is not strictly accurate. However, the concept applies in that this is a synthetic second-line analgesic, which may have different characteristics in terms of patient tolerance than traditional nonsynthetic opioids. The medical records outline patient intolerance of multiple opioids, as well as multiple traditional antiinflammatory medications. In this case, the use of second-line synthetic opioid would be supported by the guidelines. Therefore, this request is reasonable and necessary.

4. 8 sessions of aquatic therapy is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), which are part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 22, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on aquatic therapy states "Recommended as an optional form of exercise therapy, where available, as an alternative to land-based therapy." Additionally, the same guideline states regarding physical medicine "Allow for fading of treatment frequency, plus active self-directed home physical medicine." The treating provider states that aquatic therapy benefitted the patient previously with improved energy mobility. However, while that may be an indication for aquatic rather than land-based therapy if that could be assessed objectively, more importantly the guideline encourages long-term active independent home rehabilitation. Therefore, the records and guidelines do not support an indication for additional supervised aquatic therapy as requested. If there is a way to objectively or clearly demonstrate effectiveness of aquatic rather than land therapy such as specific functional benefits the patient achieves from aquatic therapy and not from land therapy, then it may be appropriate to submit a separate request for access to a pool in order to continue an independent aquatic program. However, that documentation is not available currently in the record and this request is for supervised aquatic therapy, which is not supported based on the records and guidelines. Therefore, this request is not medically necessary.

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.

[REDACTED]

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