

---

**Notice of Independent Medical Review Determination**

Dated: 10/18/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/16/2013

8/12/2001

7/25/2013

CM13-0003207

- 1) MAXIMUS Federal Services, Inc. has determined the request for left transforaminal lumbar epidural injection at L5-S1 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Hydrocodone 10/325mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Protonix 20mg **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 left transforaminal lumbar epidural injection at L5-S1 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Hydrocodone 10/325mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Protonix 20mg **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 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.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 16, 2013:

“The patient is a 70 year old female with a date of injury of 8/12/2001. Under consideration is a prospective request for one left transforaminal lumbar epidural injection at L5 and S1, one prescription of Hydrocodone 10/325mg and one prescription of Protonix 20mg.”

### **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
- Utilization Review Determination from Claims Administrator
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for left transforaminal lumbar epidural injection at L5-S1:**

Medical Treatment Guideline(s) 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), Epidural steroid injections (ESIs), which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee's date of injury is 8/12/01. The employee has been experiencing low back pain, and bilateral knee pain. Treatment to date has included epidural steroid injections and medication. The request is for a left transforaminal lumbar epidural injection at L5-S1.

The MTUS Chronic Pain Medical Treatment Guidelines specify that epidural steroid injections are recommended as an option for treatment of radicular pain. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Medical records submitted and reviewed document both improvement in pain and in function from a prior epidural steroid injection. The guideline criteria have been met. The request for a left transforaminal lumbar epidural injection at L5-S1 **is medically necessary and appropriate.**

**2) Regarding the request for Hydrocodone 10/325mg:**

Medical Treatment Guideline(s) 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), Opioids for chronic pain, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee's date of injury is 8/12/01. The employee has been experiencing low back pain, and bilateral knee pain. Treatment to date has included epidural steroid injections and medication. The request is for Hydrocodone 10/325mg.

The MTUS Chronic Pain Medical Treatment Guidelines state using opioids for chronic back pain appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Medical records submitted and reviewed document that the employee has been on opioid therapy for many months and has had abnormal drug screening that

has illicit drug use results. There is no evidence provided by the treating provider to indicate that continued long-term use of opioids for pain management is medically necessary, and the MTUS Chronic Pain Guidelines do not support continuous use of opioids. The request for Hydrocodone 10/325mg **is not medically necessary and appropriate.**

### 3) Regarding the request for Protonix 20mg:

#### Medical Treatment Guideline(s) 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), NSAIDs, GI symptoms & cardiovascular risk, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

#### Rationale for the Decision:

The employee's date of injury is 8/12/01. The employee has been experiencing low back pain, and bilateral knee pain. Treatment to date has included epidural steroid injections and medication. The request is for Protonix 20mg.

The MTUS Chronic Pain Medical Treatment Guidelines state clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recommendations specify patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.). Medical records submitted and reviewed show that the employee is not taking NSAIDs, but has gastrointestinal complaints that may be due to taking other medications. There is no evidence provided by these guidelines that Protonix would be beneficial. The request for Protonix 20mg **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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/ldh

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.