

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/22/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	9/28/2000
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0006990

- 1) MAXIMUS Federal Services, Inc. has determined the request for Ultram 50 mg #60 with 1 refill **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Transdermal Flurbiprofen #30 gm with 1 refill **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 1 transforaminal epidural bilaterally at L3-4 **is 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 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/23/2013. 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 Ultram 50 mg #60 with 1 refill **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Transdermal Flurbiprofen #30 gm with 1 refill **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 1 transforaminal epidural bilaterally at L3-4 **is 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.

### Expert Reviewer Case Summary:

This is a 54-year-old with injury from 9/23/2000 for low back and leg chronic pain. Dr. [REDACTED] hand written note from 8/15/13 show diagnoses of lumbar fusion surgery and elevated blood pressure. Note from 7/22/13 has s/p L4-5 PLIF, GI problems and the treater recommends transdermal Flurbiprofen. Pain is noted at 7-9/10. Another hand written note, has patient continuing with pain, Ultram and Celebrex was (something)... no longer authorized, will try transdermal Flubriprofen. This was Dr. [REDACTED] report from 6/18/13. 5/15/13 note by Dr. [REDACTED] has LBP, rad RLE to foot, N/T, positive weakness. No discussion regarding medication. 4/15/13 note does not discuss the specifics of meds or injection. Patient has RLE radic. 3/14/13 note has LBP (lower back pain), seen ortho spine 2/13/13 rec for ESI (epidural steroid injection). Positive GI pain with Rx. There is a reference(4/23/13 report by Dr. [REDACTED]) to ESI from 7/23/02, first one with temporary relief. This was before lumbar surgery. MRI of L-spine from 2/4/13 showed Gr 1 retrolisthesis of L3-4, moderate spinal canal and bilateral neural narrowing, with fusion at L4-S1. Dr. [REDACTED] report from 3/7/13 recommends bilateral transforaminal ESI at L3-4.

### 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 Ultram 50 mg #60 with 1 refill :**

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 (May 2009), Tramadol, Criteria for the use of opioids, Weaning of medications, which is a part of MTUS.

The Expert Reviewer based his/her decision on Chronic Pain Medical Treatment Guidelines (May 2009), Long-Term Users of Opioids, pp. 88 - 89, which is a part of MTUS.

Rationale for the Decision:

The reviewed medical records provided in this case did not document one single incidence of the treater providing documentation regarding Ultram, it's use, efficacy, pain response, functional changes, etc. MTUS guidelines require that this documentation be provided at least once every 6 months. Although this medication is indicated for chronic pain, the treater must provide documentation regarding pain relief, changes in function, quality of life due to use of medication and any adverse events. **The request for Ultram 50 mg #60 with 1 refill is not medically necessary and appropriate.**

**2) Regarding the request for Transdermal Flurbiprofen #30 gm with 1 refill :**

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 Chronic Pain Medical Treatment Guidelines (May 2009), Topical analgesics, Non-steroidal antinflammatory agents (NSAIDS), pp. 111, which is a part of MTUS.

Rationale for the Decision:

The MTUS Guidelines indicate, "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period...."

A review of the medical records indicates the employee suffers from chronic low back and leg pains with history of lumbar fusion at L4-S1. The MTUS guidelines do not recommend topical or transdermal NSAIDs for osteoarthritic pains of the spine, and do not recommend it for neuropathic pain. **The request for Transdermal Flurbiprofen #30 gm with 1 refill is not medically necessary and appropriate.**

**3) Regarding the request for 1 transforaminal epidural bilaterally at L3-4 :**

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 (May 2009), Criteria for the use of Epidural steroid injections, which is a part of MTUS.

The Expert Reviewer based his/her decision on Chronic Pain Medical Treatment Guidelines (May 2009), Epidural Steroid injections (ESIs), Criteria for the use of Epidural steroid injections, pp. 46, which is a part of MTUS.

Rationale for the Decision:

The MTUS Guidelines criteria for ESI indicates that specific radiculopathy must be documented. The medical records reviewed indicate the employee has spinal stenosis at L3-4 both centrally and bilaterally and the employee does have radicular symptoms down the leg. One reviewed medical report documents sensory changes from L3 to S1 on one side. Given the MRI findings and the employee's radicular symptoms, an ESI is indicated. The employee did try an ESI with temporary relief in 2002, but exact amount of benefit was not documented. However, since then the employee has had lumbar surgery and new MRI findings. **The request for 1 transforaminal epidural bilaterally at L3-4 is 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

/hs

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.