
Notice of Independent Medical Review Determination

Dated: 12/16/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

8/12/2013

1/23/2003

8/15/2013

CM13-0011798

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Omeprazole #30 caps is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Vicodin #30 tabs is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Cidaflex is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine 7.5mg is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Ativan #20 tabs is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Transdermals is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 8/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/7/2013. 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 **Omeprazole #30 caps** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Vicodin #30 tabs** is not medically necessary and appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Cidaflex** is not medically necessary and appropriate.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine 7.5mg** is not medically necessary and appropriate.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Ativan #20 tabs** is not medically necessary and appropriate.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Transdermals** 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 Anesthesiology, has a subspecialty in Pain Management 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 58-year-old female who reported an injury on 01/23/2003. Current diagnoses include low back sprain syndrome with left sciatica, left knee sprain and strain, and left foot sprain and strain with tendonitis over peroneus brevis. The patient was most recently seen by Dr. [REDACTED] on 06/27/2013. The patient complained of constant pain in bilateral knees. Objective findings included mild antalgic gait, joint effusion bilaterally, joint line tenderness, positive McMurray's sign bilaterally, lumbar tenderness with guarding and limited range of motion, positive straight leg raising bilaterally, tenderness with guarding and limited range of motion of the cervical spine, diminished sensation and positive compression testing. Treatment plan included an MRI of bilateral knees and continuation of current medications.

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:



1) Regarding the request for Omeprazole #30 caps:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 68-69, which is part of the MTUS.

Rationale for the Decision:

California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. As per the clinical notes submitted, there is no evidence of significant risk factors or cardiovascular disease that would place the employee at intermediate or high risk for gastrointestinal events. There is no indication as to why the employee would not benefit from the use of an over-the-counter product as opposed to a prescription medication. Additionally, the dose and frequency were not stated on the request. **The request for Omeprazole #30 caps is not medically necessary and appropriate.**

2) Regarding the request for Vicodin #30 tabs:

The Medical Treatment Guidelines 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 76-80, Criteria for use of opioids, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 74-82, which is part of the MTUS.

Rationale for the Decision:

California MTUS Guidelines state short-acting opioids are often used for intermittent or breakthrough pain. The duration of action is generally 3 to 4 hours. A therapeutic trial of opioids should not be employed until the patient has

failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. There is no evidence of improved function and pain through usage of the opioid agent in question. An original request for Vicodin 5/500 mg was non-certified on 10/22/2012, therefore, weaning or tapering of this medication should have occurred. The clinical note dated 06/27/2013 stated that the employee presented with complaints of constant pain in bilateral knees. Objective findings included mild antalgic gait, effusion, joint line tenderness, positive McMurray's, lumbar spine tenderness, guarding with limited range of motion, positive straight leg raising, cervical spine tenderness with guarding and limited range of motion, diminished sensation, and a positive compression testing. Satisfactory response to treatment has not been indicated by the employee's decrease in pain, increase in level of function, or improved quality of life. **The request for Vicodin #30 tabs is not medically necessary and appropriate.**

3) Regarding the request for Cidaflax:

The Medical Treatment Guidelines 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, page 50, which is part of the MTUS.

Rationale for the Decision:

California MTUS Guidelines state glucosamine and chondroitin sulfate is recommended as an option given its low risk, in patients with moderate arthritis pain. As per the clinical notes submitted, the documentation does not clearly establish the presence of radiographic and/or clinical evidence of knee osteoarthritis. Therefore, the continued use of this medication cannot be determined as medically appropriate. There is also no indication as to why the employee would not benefit from an over-the-counter product as opposed to a prescription medication. **The request for Cidaflax is not medically necessary and appropriate.**

4) Regarding the request for Cyclobenzaprine 7.5mg:

The Medical Treatment Guidelines 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 63-66, Muscle relaxants (for pain), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 63-66, which is part of the MTUS.

Rationale for the Decision:

California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. However, in most lower back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. Cyclobenzaprine is recommended for a short course of therapy. Limited evidence does not allow for a recommendation of chronic use. This medication is not recommended to be used for longer than 2 to 3 weeks. As per the clinical notes submitted, the employee has failed to demonstrate any evidence of functional improvement through prior usage of this medication. The employee has failed to return to work and has failed to demonstrate any improvement in terms of work status, activities of daily living, and/or diminished reliance on medical treatment. As guidelines do not recommend use of this medication for longer than 2 to 3 weeks, ongoing use cannot be determined as medically appropriate. **The request for Cyclobenzaprine 7.5mg is not medically necessary and appropriate.**

5) Regarding the request for Ativan #20 tabs:

The Medical Treatment Guidelines 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 decisions on the Chronic Pain Medical Treatment Guidelines, page 24, which is part of the MTUS.

Rationale for the Decision:

California MTUS Guidelines state Benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Per the clinical notes submitted, the employee has failed to demonstrate functional improvement through prior use of this medication. As guidelines do not recommend use of this medication for longer for 4 weeks, the ongoing use cannot be determined as medically appropriate. A previous utilization review on 10/22/2012 issued a non-certification of this medication as well. Additionally noted, the dosage and frequency were not stated on the recurrent request. **The request for Ativan #20 tabs is not medically necessary and appropriate.**

6) Regarding the request for Transdermals:

The Medical Treatment Guidelines 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 made his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 111-113, which is part of the MTUS.

Rationale for the Decision:

There is no documentation of the specific name, dosage, and frequency of transdermal medication being requested. Additional information is required regarding this request. A previous utilization review report submitted on 10/22/2012 also issued non-certification and requested additional information for this specific request. The information has yet to be received. **The request for Transdermals 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

/skf

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.