

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



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**Notice of Independent Medical Review Determination**

Dated: **11/27/2013**

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/8/2013  
Date of Injury: 10/31/1999  
IMR Application Received: 8/26/2013  
MAXIMUS Case Number: CM13-0012533

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Cymbalta 60mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Neurontin 600mg #150 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Norco 10/325mg #150 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/26/2013 disputing the Utilization Review Denial dated 8/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/26/2013. 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 retrospective request for **Cymbalta 60mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Neurontin 600mg #150 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Norco 10/325mg #150 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 Internal Medicine, has a subspecialty in Rheumatology 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:**

This 74 year old female was injured 10/31/99. The mechanism of injury was cumulative trauma. A lumbar spine MRI showed degenerative disc disease and lumbar spinal stenosis. No surgery has been reported to this reviewer pertinent to this injury. The requesting provider's medical report dated 07/13 stated that the patient complained of low back pain. Diagnosis: lumbar spine degenerative disc disease and spinal stenosis. Treatment plan and request: Norco, Neurontin, Cymbalta.

### **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 retrospective request for Cymbalta 60mg #60 :**

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, pg 15-16, 79-81, which are part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg 43, which is part of MTUS.

Rationale for the Decision:

This employee has reported chronic lower back pain, and has been diagnosed with degenerative disc disease and spinal stenosis. The available documents show no evidence of a condition for which Cymbalta is indicated. Cymbalta has not been proven to be effective for spine disc disease. Furthermore, the employee was treated with this medication for at least a 6 month period without documented improvement in symptoms. **The retrospective request for Cymbalta 60mg #60 is not medically necessary and appropriate.**

**2) Regarding the retrospective request for Neurontin 600mg #150 :**

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, pg 16-17, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg 49, which is part of MTUS.

Rationale for the Decision:

This employee has reported chronic lower back pain, and has been diagnosed with degenerative disc disease and spinal stenosis. The available documents show no evidence of a condition for which Neurontin is indicated. Neurontin has not been proven to be effective for spine disc disease. Furthermore, the employee was treated with this medication for at least a 6 month period without documented improvement in symptoms. **The retrospective request for Neurontin 600mg #150 is not medically necessary and appropriate.**

**3) Regarding the retrospective request for Norco 10/325mg #150 :**

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, pg 79-81, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg 76-85, 88-89 which is part of MTUS.

Rationale for the Decision:

This employee has reported chronic lower back pain, and has been diagnosed with degenerative disc disease and spinal stenosis. The available medical records show no documentation of goal setting with the use of opioids and no documentation of baseline or subsequent function assessment to include social, physical, daily and work related activities. There is no assessment of appropriate medication use or side effects. **The retrospective request for Norco 10/325mg #150 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, 18<sup>th</sup> 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.