

Notice of Independent Medical Review Determination

Dated: 12/4/2013

[REDACTED]

[REDACTED]

Employee:

[REDACTED]

[REDACTED]

Date of UR Decision:

8/6/2013

Date of Injury:

12/30/2006

IMR Application Received:

8/13/2013

MAXIMUS Case Number:

CM13-0012925

- 1) MAXIMUS Federal Services, Inc. has determined the request for **MRI of the lumbar spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine (Fexmid) 7.5 mg #60 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Diclofenac (Voltaren XR) 100 mg #60 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 8/6/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/19/2013. 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 **MRI of the lumbar spine** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine (Fexmid) 7.5 mg #60** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Diclofenac (Voltaren XR) 100 mg #60** 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 Orthopedic Surgery, 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 60-year-old male who was injured on 12/30/2006. The patient has chronic low back pain. Physical examination dated 5/29/2013 demonstrates negative straight leg raise. The provider has prescribed Naproxen and Vicodin. Follow-up examination on 7/9/2013 demonstrated positive straight leg raise and subjective weakness reported in extensor hallicus longus and tibialis anterior.

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 MRI of the lumbar spine

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 ACOEM Guidelines, Chapter 12 (Low Back Complaints) (2004), pg 53, which is part of the MTUS, and the Official Disability Guidelines, Low Back (Acute & Chronic), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), which is part of MTUS.

Rationale for the Decision:

Per the MTUS/ACOEM Guidelines, a lumbar MRI may be recommended for diagnosing red flag symptoms including progressive neurologic deficit, cauda equina syndrome, significant trauma without improvement in atypical symptoms, a history of neoplasia (cancer), or atypical presentation (e.g., clinical picture suggests multiple nerve root involvement). In addition, MRI may be recommended for diagnosing radicular symptoms after 4-6 weeks when symptoms are not improving and surgery is being considered or at 3-4 weeks when an epidural steroid injection is being considered. The records submitted for review fail to document such indication for the requested diagnostic procedure.

The request for MRI of the lumbar spine is not medically necessary and appropriate.

2) Regarding the request for Cyclobenzaprine (Fexmid) 7.5 mg #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, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42, which is part of MTUS.

Rationale for the Decision:

The MTUS Chronic Pain guidelines indicate that Cyclobenzaprine may be indicated for a short course of therapy in the treatment of acute low back pain and spasm. The records provided for review document chronic low back pain without spasm. **The request for Cyclobenzaprine (Fexmid) 7.5 mg #60 is not medically necessary and appropriate.**

3) Regarding the request for Diclofenac (Voltaren XR) 100 mg #60

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 the Chronic Pain Medical Treatment Guidelines, NSAIDs, which is part of MTUS.

Rationale for the Decision:

The MTUS Chronic Pain guidelines on NSAIDs recommend the lowest dose for the shortest period in patients with moderate to severe pain. The records submitted for review lack documentation of this employee's response to previously prescribed Naproxen to support the medical necessity for Voltaren XR tablets. **The request for Diclofenac (Voltaren XR) 100 mg #60 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

/sab

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.