

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/8/2013  
Date of Injury: 6/29/2011  
IMR Application Received: 8/21/2013  
MAXIMUS Case Number: CM13-0014443

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiologist and Pain Medicine and is licensed to practice in California and Florida. 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 physician 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 disputed items/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 48-year-old female who reported an injury on 09/14/2011. The patient is currently diagnosed with lumbar discopathy. She was most recently seen by Dr. [REDACTED] on 06/13/2013. Physical examination revealed increased weakness in the left lower extremity with positive straight leg raise, as well as weak plantar flexors. Treatment plan included an L5-S1 left-sided hemilaminectomy and microdiscectomy with neural decompression. The patient was also given prescriptions for Naproxen, Cyclobenzaprine, Omeprazole, Tramadol, and Medrox pain relief ointment.

### IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **1. 120 Omeprazole 20mg is not medically necessary and appropriate.**

The Claims Administrator based its decision on the the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

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

The Physician Reviewer's decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients that are 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. The medical records provided for review does not indicate risk factors for gastrointestinal events. There is no evidence of subjective complaints or objective findings of a gastrointestinal disorder. There is also 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. **The request for 120 Omeprazole 20mg is not medically necessary and appropriate.**

**2. Two prescriptions for Ondansetron ODT 8mg, quantity 90 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Chronic Pain Chapter, Online Edition, which is not part of the MTUS.

The Physician Reviewer's decision rationale: Official Disability Guidelines state Ondansetron, or Zofran, is not recommended for nausea and vomiting secondary to chronic opioid use. Anti-emetics are only recommended for acute use as noted by FDA approved indications. Nausea and vomiting is common with the use of opioids. These side effects tend to diminish over days to weeks of continued exposure. Zofran is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment, and has been FDA approved for postoperative use. The medical records provided for review does not indicate that the employee meets the criteria for the use of Zofran. **The request for two prescriptions of Ondansetron ODT 8mg, quantity 90 is not medically necessary and appropriate.**

**3. 120 Cyclobenzaprine 7.5mg is not medically necessary and appropriate.**

The Claims Administrator based its decision on Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

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

The Physician Reviewer's decision rationale: 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 low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Cyclobenzaprine is recommended for a short course of therapy, and is not recommended to be used longer than 2 weeks to 3 weeks. The medical records provided for review does not include documentation upon physical examination of palpable muscle spasms or muscle tension. There is also no evidence of a failure to respond to a first line option prior to initiation of a muscle relaxant. **The request for 120 Cyclobenzaprine 7.5mg is not medically necessary and appropriate.**

**4. Two prescriptions of Medrox 120mg ointment is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 111-113, which is part of the MTUS.

The Physician Reviewer's decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Capsaicin is recommended only as an option in patients who have not responded to, or are intolerant to, other treatments. Indications include osteoarthritis, fibromyalgia, and chronic nonspecific back pain. The medical records provided for review reflects that the employee does have a diagnosis of lumbar discopathy, and suffers from chronic lower back pain. However, there is no evidence of a failure to respond to previous treatments, including oral antidepressants and anticonvulsants. **The request for two prescriptions of Medrox 120mg ointment is not medically necessary and appropriate.**

#### **5. 90 Tramadol ER 150mg is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

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

The Physician Reviewer's decision rationale: California MTUS Guidelines state therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. A written consent or pain agreement for chronic use is not required, but may make it easier for the physician and surgeon to document the patient's education, treatment plan, and informed consent. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Opioids should be discontinued when there is no overall improvement in function, unless there are extenuating circumstances. The medical records provided for review notes that the employee reports ongoing pain with progressive neurological deficit. Satisfactory response to treatment is not indicated by the employee's decrease in pain level, increase in functional level, or overall improved quality of life. **The request for 90 Tramadol ER 150mg is not medically necessary and appropriate.**

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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.



CM13-0014443