

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	6/30/2000
IMR Application Received:	8/23/2013
MAXIMUS Case Number:	CM13-0015967

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Halcion 0.25 mg #30 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Flurbiprofen/Cyclobenzaprine 15/10% cream 180 gm is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol/Gabapentin/Menthol/Capmhor/Capsaicin 8/10/2/2/.05% cream 180 gm is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/23/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/10/2013. 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 **Halcion 0.25 mg #30 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Flurbiprofen/Cyclobenzaprine 15/10% cream 180 gm is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol/Gabapentin/Menthol/Capmhor/Capsaicin 8/10/2/2/.05% cream 180 gm 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 Family Practice, has a subspecialty in Preventive Medicine 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:

67 yr. old female claimant who sustained an injury on 6/30/2000 with resultant chronic knee pain and shoulder pain. An examination report on 6/28/13 noted burning pain in bilateral knees, joint line tenderness and an antalgic gait. She had the following diagnoses: left shoulder impingement with rotator tear, left knee derangement and right knee osteoarthritis. Medications prescribed at the time include: Halcion for sleep, Flurbiprofen /Cyclobenzaprine cream, for anti-inflammatory and Tramadol/Gabapentin/Menthol/Camphor cream, for neuropathic pain.

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 Halcion 0.25 mg #30:

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, Benzodiazapines, page 24, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazapines, page 24, which is part of the MTUS, and the Official Disability Guidelines (ODG) Benzodiazepines and Insomnia, which is not part of the MTUS.

Rationale for the Decision:

Halcion is a Benzodiazepine which, according to the MTUS Chronic Pain Guidelines, is not recommended for long-term use because it's efficacy is unproven and there is a risk of addiction. Most guidelines limit its use to four weeks and its range of action include: sedation, anxiolytic, anticonvulsant and muscle relaxant. According to the ODG guidelines, Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids. Chronic benzodiazepines are the treatment of choice in very few conditions. Adults who use hypnotics, including benzodiazepines, have a greater than 3-fold increased risk for early death, according to results of a large matched cohort survival analysis. Furthermore, according to the ODG guidelines, FDA-approved benzodiazepines for sleep maintenance insomnia, including Halcion, are FDA-approved for sleep-onset insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence and adverse events. In this case, the etiology of sleep disturbance is not explained in the documentation provided for review. There is no documentation of attempt in sleep hygiene, or the intended length of treatment. There is no mention of a sleep study. Furthermore, the use of this medication along with other medications such as opioids, including Tramadol, which the employee had been given, can compound the risk of death. **The request for Halcion 0.25 mg #30 is not medically necessary and appropriate.**

2) Regarding the request for Flurbiprofen/Cyclobenzaprine 15/10% cream 180 gm:

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 MTUS, and Official Disability Guidelines (ODG), Pain Chapter, Topical Analgesics, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-112, which is part of the MTUS.

Rationale for the Decision:

Cyclobenzaprine is a muscle relaxant. According to the MTUS Chronic Pain guidelines, there is no evidence to support the use of topical muscle relaxants in the documentation provided for review. Any compounded medication that contains a medication that is not recommended is not recommended. **The request for Flurbiprofen/Cyclobenzaprine 15/10% cream 180 gm is not medically necessary and appropriate.**

**3) Regarding the request for
Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/1/1/.05% cream 180 gm**

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 MTUS, and Official Disability Guidelines (ODG), Pain Chapter, Topical Analgesics, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-112, which is part of MTUS.

Rationale for the Decision:

According to the MTUS Chronic Pain guidelines, Capsaicin is recommended in doses under 0.025%. An increase over this amount has not been shown to be beneficial. In this case, the medication above contains a higher amount of Capsaicin than is medically necessary. As per the guidelines, any compounded medication that contains a medication that is not recommended is not recommended. **The request for
Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/2/.05% cream
180gm 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

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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.