

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/16/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
[REDACTED] UR Decision:	8/12/2013
Date of Injury:	3/23/2010
IMR Application Received:	8/26/2013
MAXIMUS Case Number:	CM13-0016696

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Flurbiprofen, #20 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **cyclobenzaprine, #20 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 8/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **Flurbiprofen, #20 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **cyclobenzaprine, #20 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 Maryland. 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 38 year old male was injured March 25, 2010. Mechanism of injury was slipping and subsequent fall. Available medical records indicate a right knee arthroscopic surgery and an MRI of the right knee without noted dates of completion. The requesting provider's medical reports dated indicate that the patient had continued lower back pain, bilateral groin pain and right knee pain. The patient has been treated with the surgery listed above and medications. The above medications were requested June 17, 2013 and there is no documentation providing reasoning for these requests.

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 Treatment Utilization Schedule (MTUS)
- Medical Records from Claims Administrator

1) Regarding the request for Flurbiprofen, #20:

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 (2009), pages 67-68, and the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition (2004), Chapter 12, page 299, and Chapter 13, page 338, which are part of the MTUS.

Rationale for the Decision:

This employee has chronic right knee pain and chronic low back pain and has been diagnosed with osteoarthritis of the right knee and chronic lumbar spine pain. The medical records provided for review show a request for treatment with Flurbiprofen. No treating physician reports show the employee's level of function or document inadequate pain control at the time of medication request. No physician reports document an escalation or worsening of pain at the time of medication request. There is no discussion of other treatment options for these conditions which are chronic (greater than 3 years) since date of injury nor any discussion of possible specific benefit. Non-steroidal anti-inflammatory drugs are indicated for short term symptomatic relief only. There is documentation of a naproxen prescription trial on October 2012 with no subsequent notation regarding the employee's response or length of duration of treatment with this agent. With this lack of documentation, the current request for flurbiprofen can not be considered medically necessary. **The request for Flurbiprofen #20 is not medically necessary and appropriate.**

2) Regarding the request for cyclobenzaprine, #20:

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 (2009), page 41, which is part of the MTUS and the ACOEM Guidelines, pages 299 and 338, which are part of the MTUS.

Rationale for the Decision:

The available medical records show a request for treatment with cyclobenzaprine, which the employee has been taking since September 25, 2013. No treating physician reports show the employee's level of function or document inadequate pain control at the time of medication request. Muscle relaxant agents (cyclobenzaprine) are not recommended for chronic use or a greater than 2-3 week period, nor per MTUS guidelines should they be used with other pain medications. **The request for cyclobenzaprine 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

/dso

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.