

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: 8/7/2013
Date of Injury: 9/11/2004
IMR Application Received: 8/29/2013
MAXIMUS Case Number: CM13-0018077

- 1) MAXIMUS Federal Services, Inc. has determined the request for one left L3, L4, L5 dorsal medial branch block 7/24/2013 and 10/4/2013 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Neurontin 300mg #90 7/24/2013 and 7/24/2013 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Robaxin 750mg #120 7/24/2013 and 7/24/2013 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Trazodone 50-100mg #120 7/24/2013 and 7/24/2013 **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/29/2013 disputing the Utilization Review Denial dated 8/7/2013. 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 one left L3, L4, L5 dorsal medial branch block 7/24/2013 and 10/4/2013 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Neurontin 300mg #90 7/24/2013 and 7/24/2013 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Robaxin 750mg #120 7/24/2013 and 7/24/2013 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Trazodone 50-100mg #120 7/24/2013 and 7/24/2013 **is 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 Occupational 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:

The applicant is a represented [REDACTED] who has filed a claim for chronic neck, shoulder, and low back pain reportedly associated with an industrial injury of September 11, 2004.

Thus far, the applicant has been treated with the following: Analgesic medications; adjuvant medications; unspecified amounts of acupuncture; reported return to part-time modified work; and the apparent imposition of permanent work restrictions.

In a utilization report of August 7, 2013, the claims administrator denied a request for medial branch blocks, denied a request for Neurontin, certified a request for Norco, denied a request for Robaxin, and denied a request for trazodone.

An earlier clinical progress report of July 24, 2013 is notable for comments that the applicant reports continued neck and left shoulder pain. The primary focus of complaint, however, is low back pain radiating to the left leg. Gabapentin is helping her sleep but is not entirely alleviating her leg pain. Her pain score reduces to 7/10 with medication as opposed to 9/10 without medication. The applicant has returned to part-

time work. She walks slowly and stiffly and exhibits decreased range of motion about the lumbar spine. Recommendations are made for the applicant to employ Norco, Robaxin, and Desyrel for pain relief. Permanent work restrictions are renewed. The applicant is asked to try home exercises and consider medial branch blocks.

In a later appeal letter of September 19, 2013, the attending provider notes that the applicant was using trazodone for insomnia. It is stated that gabapentin, Robaxin, and trazodone were helping with her burning pain.

It is stated that medial branch blocks are being sought for diagnostic purposes.

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:

- [REDACTED]

1) Regarding the request for one left L3, L4, L5 dorsal medial branch block 7/24/2013 and 10/4/2013:

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), Table 12-8, pg. 300, 309; and the Chronic Pain Medical Treatment Guidelines (May 2009), which are part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) Table 12-8 pg. 310, which is a part of MTUS, and the ACOEM Guidelines, 3rd Edition, Low Back, Injection Therapies, which is not part of the MTUS.

Rationale for the Decision:

The MTUS-ACOEM Guidelines state facet joint injections are not recommended. It is further noted that diagnostic facet joint injections, as are being proposed here, are not recommended for treatment of any "radicular pain syndrome." In this case, medical records provided for review indicate the employee does have radicular complaints pertaining to low back and left lower extremity. Pursuing facet joint injections in this context is not indicated. **The request for one left L3, L4, L5 dorsal medial branch block is not medically necessary and appropriate.**

2) Regarding the request for Neurontin 300mg #90 7/24/2013 and 7/24/2013:

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 California Chronic Pain Medical Treatment Guidelines (May 2009).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section - 8 C.C.R. §§9792.20 – 9792.26, Page 49 of 127, which is a part of MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines state Gabapentin or Neurontin is an anticonvulsant medication which has become a first-line treatment for neuropathic pain. In this case, the clinical documentation states the employee's persistent complaints of low back pain radiating to left leg do indicate the presence of a neuropathic component. It is further noted that the employee has used this particular agent chronically and does appear to have derived some benefit and functional improvement in terms of the same. The employee has returned to modified, part-time work and does report reduction in pain scores effected through ongoing usage of Neurontin. Continuing the same is indicated in this context. **The request for Neurontin 300mg #90 is medically necessary and appropriate.**

3) Regarding the request for Robaxin 750mg #120 7/24/2013 and 7/24/2013:

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 California Chronic Pain Medical Treatment Guidelines (May 2009).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section - 8 C.C.R. §§9792.20 – 9792.26, Page 63 and 65, which are part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines state muscle relaxants are recommended for short-term usage in the treatment of acute exacerbations of chronic pain. They are not recommended on a twice daily, 120 tablets a month basis, as is being proposed here. It is further noted that the employee is using numerous other analgesic and adjuvant medications, two of which have been certified during this independent medical review. Concurrent usage of multiple medications does make polypharmacy and sedation associated with medications a very real concern. **The request for Robaxin 750mg #120 is not medically necessary and appropriate.**

4) Regarding the request for Trazodone 50-100mg #120 7/24/2013 and 7/24/2013:

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 Official Disability Guidelines, Pain (Chronic), which are not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section - 8 C.C.R. §§9792.20 – 9792.26, Page 13 of 127, which is a part of MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines state antidepressants such as trazodone do have a widely established role as a first-line option for neuropathic pain and for treating secondary depression associated with chronic pain. In this case, the documentation on file does clearly establish the presence of ongoing complaints of neuropathic pain for which trazodone, an atypical antidepressant, is indicated. It is further noted that the employee here has exhibited some functional improvement through ongoing usage of trazodone. The employee has returned to work and does report reduction in pain effected through ongoing usage of trazodone. **The request for Trazadone 50-100mg is 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

/hs

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.