

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 8/22/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/9/2013
Date of Injury: 5/19/2010
IMR Application Received: 7/10/2013
MAXIMUS Case Number: CM13-0001087

- 1) MAXIMUS Federal Services, Inc. has determined the Cidaflex #90i requested is **not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the Medrox patch #30 requested is **not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the Prilosec 20mg #30 requested is **medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the Serrapeptase 500mg #60> requested is **not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the Skelaxin 800mg #30 requested is **medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the Kava Kava #30 requested is **not medically necessary and appropriate.**

- 7) MAXIMUS Federal Services, Inc. has determined the TGHot ointment requested **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the Imitrex 6mg injectable #6 requested **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/10/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/11/2013. 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 Cidaflex #90i requested is **not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the Medrox patch #30 requested is **not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the Prilosec 20mg #30 requested is **medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the Serrapeptase 500mg #60> requested is **not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the Skelaxin 800mg #30 requested is **medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the Kava Kava #30 requested is **not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the TGHot ointment requested is **not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the Imitrex 6mg injectable #6 requested 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 Physical Medicine and Rehabilitation 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013.

“CLINICAL SUMMARY: [REDACTED] is a 53 year old (DOB: 06/11/60) female California Highway Patrol Officer. The original date of injury appears to be related to her being rear-ended at a high rate of speed in 1989. Through the years has had periodic

flare-ups requiring treatment. The date of injury is noted to be 05/19/10. The carrier has accepted lumbar and/or sacral vertebra, disc-Neck and soft tissue head. The carrier has denied acceptance of abdomen/groin. Her work status is not documented.”

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 for Independent Medical Review (received 7/10/13)
- Utilization review determination from [REDACTED] (dated 7/9/13)
- Employee medical records from [REDACTED] (dated 2/14/13-5/30/13)
- Employee medical records from [REDACTED] (dated 12/3/12-1/15/13)
- Employee medical records from [REDACTED] (dated 5/25/12-10/17/12)
- Employee medical records from [REDACTED] (dated 11/28/12)
- Employee medical records from [REDACTED], DC (6/18/12-2/4/13)
- Employee medical records from [REDACTED], MD (6/18/12)
- Employee medical records from [REDACTED], MD (dated 1/10/13-2/14/13)
- Employee medical records from [REDACTED], MD (dated 10/15/12)
- Employee medical records from [REDACTED], MD (dated 12/3/12-6/21/13)
- Employee medical records from [REDACTED], MD (dated 4/25/12-11/14/12)
- Employee medical records from [REDACTED], Lac (dated 1/8/13-2/1/13)
- Employee medical records from [REDACTED] (dated 12/7/12)

1) Regarding the request for Cidaflex #90i:

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 (ODG), which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that no section of the MTUS was relevant for the issue at dispute. The Expert Reviewer found the Official Disability Guidelines (ODG), Low Back Chapter, which is not part of the Medical Treatment Utilization Schedule (MTUS) relevant and appropriate for the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 5/19/2010. The medical records provided and reviewed indicate accepted body parts for treatment are lumbar region, neck, and head and that treatment has consisted of cervical fusion, lumbar epidural injections, and oral and topical analgesics. The request is for Cidaflex #90.

The Official Disability Guidelines specifically state Cidaflex is not recommended for low back pain. The medical records reviewed indicate treatment includes the low back. The Cidaflex #90 **is not medically necessary and appropriate.**

2) Regarding the request for Medrox patch #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 – Division of Workers’ Compensation and Official Disability Guidelines References (May, 2009), pg. 111-113, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 28-29, 105, 111-113, which is part of the Medical Treatment Utilization Schedule (MTUS) applicable and relevant for the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 5/19/2010. The medical records provided and reviewed indicate accepted body parts for treatment are lumbar region, neck, and head and that treatment has consisted of cervical fusion, lumbar epidural injections, and oral and topical analgesics. The request is for Medrox patch #30.

MTUS Chronic Pain guidelines state a compound medication that contains one drug or drug class that is not recommended would not allow recommendation of the compound. Medrox is a compound medication containing capsaicin which is only recommended as an option for those who have not responded to or are intolerant to other treatments. The medical records reviewed show that Medrox patches were prescribed on the initial evaluation on 2/16/13, and does not appear to document a trial of other treatments. The Medrox patch #30 **is not medically necessary and appropriate.**

3) Regarding the request for Prilosec 20mg #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 – Division of Workers’ Compensation and Official Disability Guidelines References (May, 2009), pg. 68-69, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 5/19/2010. The medical records provided and reviewed indicate accepted body parts for treatment are lumbar region, neck, and head and that treatment has consisted of cervical fusion, lumbar epidural injections, and oral and topical analgesics. The request is for Prilosec 20mg #30.

MTUS Chronic Pain guidelines state a proton pump inhibitor such as Prilosec may be utilized for those taking NSAIDs and experiencing gastrointestinal (GI) issues. The records provided for review indicate the employee is taking Voltaren, an NSAID, and there is a history of acid reflux and GI upset. The Prilosec 20mg #30 **is medically necessary and appropriate.**

4) Regarding the request for Serrapeptase 500mg #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 basis for its decision. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer found that no section of the Medical Treatment Utilization Schedule (MTUS) was applicable. The Expert Reviewer found no applicable and relevant Medical Treatment Guideline, Nationally Recognized Professional Standard, Expert Opinion, or generally accepted standard of medical practice. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on treatments likely to benefit a patient after other treatments are not clinically efficacious.

Rationale for the Decision:

The employee sustained a work-related injury on 5/19/2010. The medical records provided and reviewed indicate accepted body parts for treatment are lumbar region, neck, and head and that treatment has consisted of cervical fusion, lumbar epidural injections, and oral and topical analgesics. The request is for Serrapeptase 500mg #60.

The requested treatment, Serrapeptase, lacks evidence-based support and is not a medication. The hierarchy of evidence does allow for treatment likely to benefit a patient after other treatments are not efficacious. The medical records reviewed, however, indicate the Serrapeptase was prescribed on 2/16/13, which was an initial visit, indicating the prescribing physician did not try other treatments and report the outcome prior to prescribing the Serrapeptase. Serrapeptase 500mg #60 **is not medically necessary and appropriate.**

5) Regarding the request for Error! Reference source not found.:

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 – Division of Workers' Compensation and Official Disability Guidelines References (May, 2009), pg. 64-66, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance, and additionally found the Chronic Pain Medical Treatment Guidelines – Division of Workers' Compensation

and Official Disability Guidelines References (May, 2009), pg. 8 of 127 applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 5/19/2010. The medical records provided and reviewed indicate accepted body parts for treatment are lumbar region, neck, and head and that treatment has consisted of cervical fusion, lumbar epidural injections, and oral and topical analgesics. The request is for Skelaxin 800mg #30.

MTUS Chronic Pain guidelines indicate antispasmodics (Skelaxin) are utilized to decrease muscle spasms in the treatment of musculoskeletal conditions. The medical records reviewed indicate exam findings of increased cervical muscle tension as early as 2/16/13. The medical record of 3/4/13 indicates a decreased pain level after the use of the Skelaxin. MTUS attributes a decrease in pain as a satisfactory response to treatment, and associates the decrease in pain with improved function. This meets the criteria for continued use. The Skelaxin 800mg # 30 is medically necessary and appropriate.

6) Regarding the request for Error! Reference source not found.:

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 basis for its decision. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer found that no section of the Medical Treatment Utilization Schedule (MTUS) was applicable. The Expert Reviewer found no applicable and relevant Medical Treatment Guideline, Nationally Recognized Professional Standard, Expert Opinion, or generally accepted standard of medical practice. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on treatments likely to benefit a patient after other treatments are not clinically efficacious.

Rationale for the Decision:

The employee sustained a work-related injury on 5/19/2010. The medical records provided and reviewed indicate accepted body parts for treatment are lumbar region, neck, and head and that treatment has consisted of cervical fusion, lumbar epidural injections, and oral and topical analgesics. The request is for Kava Kava #30.

The requested treatment, Kava Kava, lacks evidence-based support and is not a medication. The hierarchy of evidence does allow for treatment likely to benefit a patient after other treatments are not efficacious. The medical records reviewed, however, indicate the Kava Kava was prescribed on 3/4/13 with a decrease in pain levels at the next visit after taking the Kava Kava. However, the 6/21/13 medical report indicates the Kava Kava had not been taken due to lack of authorization, and pain levels were still decreased. Non-reduction of pain is not a

satisfactory response for a product intended to help reduce pain. Kava Kava #30 **is not medically necessary and appropriate.**

7) Regarding the request for Error! Reference source not found.:

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 basis for its decision. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer found that no section of the Medical Treatment Utilization Schedule (MTUS) was applicable. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, Topical Analgesics, pg.111-113 relevant and appropriate to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 5/19/2010. The medical records provided and reviewed indicate accepted body parts for treatment are lumbar region, neck, and head and that treatment has consisted of cervical fusion, lumbar epidural injections, and oral and topical analgesics. The request is for TGHot ointment.

MTUS Chronic Pain guidelines state topical analgesics are largely experimental. An internet search did not uncover any product by this name, and medical records reviewed gave no description as to what this ointment is, or what it was intended to treat. Based on an inability to know the components of the prescribed cream, and MTUS guidelines indicating topical analgesics are experimental, the TGHot ointment **is not medically necessary and appropriate.**

8) Regarding the request for Error! Reference source not found.:

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 (ODG), Head Chapter, Triptans, which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that no section of the MTUS was relevant to the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 5/19/2010. The medical records provided and reviewed indicate accepted body parts for treatment are lumbar region, neck, and head and that treatment has consisted of cervical fusion, lumbar epidural injections, and oral and topical analgesics. The request is for Imitrex 6mg, injectable #6.

Official Disability Guidelines (ODG) state Triptans are indicated for treatment of migraine headaches. The medical records reviewed document a history of migraine headaches for the employee. The request for Imitrex 6 mg, injectable #6 **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,

Richard C. Weiss, MD, MPH, MMM, PMP
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.