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## Notice of Independent Medical Review Determination

Dated: 8/21/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/2/2013

2/25/2002

7/11/2013

CM13-0001174

- 1) MAXIMUS Federal Services, Inc. has determined the request for the diagnostic facet injection bilaterally at L3-4, L4-5 and L5-S1 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for the Exalgo ER 16mg #150 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for the Fentora 400 mg #84 **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for the Baclofen 10mg #120 **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for the Flexeril 10mg #180 **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for the Klonopin 1mg #30 **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/11/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/12/2013. 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 the diagnostic facet injection bilaterally at L3-4, L4-5 and L5-S1 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for the Exalgo ER 16mg #150 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for the Fentora 400 mg #84 **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for the Baclofen 10mg #120 **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for the Flexeril 10mg #180 **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for the Klonopin 1mg #30 **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 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 2, 2013

“The patient is a 58 year old male with a date of injury of 2/25/2002. Under consideration is the request for 1 diagnostic facet injection bilaterally at L3-4, L4-5 and L5-S1, 1 prescription of Exalgo ER 16mg #150, 1 prescription of Oxycodone 30mg #270, 1 prescription of Fentora 400 meg #84, 1 prescription of Baclofen 10mg #120 from 6/7/2013, 1 prescription of Flexeril 10mg #180 from 6/17/2013, 1 prescription of Klonopin 1mg #30 from 6/7/2013, and 1 prescription of Laxacin 8.6mg #200 from 6/7/2013.

“Review of submitted documentation revealed the patient has been under treatment for chronic pain in his low back, left knee, and right shoulder. During the most recent visit on 6/7/13, the patient was experiencing axial pain worse on the right, and radicular pain rated 7-8/10 noting difficulty lying on right at night. He continues taking Exalgo for baseline pain, Flexeril for muscle spasms during day, baclofen for spasms at night, Klonopin for anxiety and spasms, Cymbalta for depression and pain, Lunesta for sleep issues, Testim 1% cream for testosterone replacement, Laxacin for constipation, and Nuvigil for daytime somnolence. Upon examination, there was sciatic notch tenderness bilaterally, focal tenderness over the facets on right and left, positive facet provocation tests on both sides, and tenderness remained over the SI joints. He had significant pain with flexion and extension, decrease motion in lumbar spine, notable paraspinous muscle spasms in lumbar area with spasms in posterior aspect of leg as well, and motor weakness in left ankle in dorsiflexion 4+/5. The left knee was tender to palpation along joint lines and over the patella with some edema in the knee, and he continues to wear a brace, favoring his left side during ambulation due to knee issues. Current diagnosis were multilevel lumbago with bilateral radiculopathy, status post spinal cord stimulator implantation, sacroiliac joint and facet joint arthropathy, myofascial syndrome, reactive sleep disturbance and reactive depression and anxiety, left knee arthropathy, status post surgery with anterior cruciate ligament repair, and right shoulder arthropathy. Dr. [REDACTED] requested diagnostic facet injections, discontinuation of Exalgo, and continuation of all other medications. In a 4/16/13 report from [REDACTED], PA-C, I+ reflexes with absent ankle jerk was 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 7/11/13)
- Utilization Review Determination (dated 7/2/13)
- Employee medical records from [REDACTED], MD (dated 6/8/12-6/7/13)
- Employee medical records from [REDACTED] (dated 4/16/13/5/3/13)
- Employee medical records from [REDACTED] MD (1/31/13)
- Employee medical records from [REDACTED] (dated 7/23/12-3/20/13)
- Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12), pg 309-310
- Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, 39-47, 63-64, 74-93, 113

#### **1) Regarding the request for the diagnostic facet injection, bilaterally at L3-4, L4-5 and L5-S1:**

##### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12), pg. 300-301, 309, 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 that the MTUS is not applicable and relevant to the issue at dispute. The Expert Reviewer found that the Official Disability Guidelines (ODG), Low Back, Facet joint diagnostic blocks (injections), which are not part of the MTUS, were applicable and relevant for the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 2/25/2002. The medical records provided for review indicate diagnoses of multilevel lumbago with bilateral radiculopathy; status post spinal cord stimulator (SCS) implant; SI joint and facet arthropathy; myofascial syndrome; reactive sleep disturbance; depression; anxiety; left knee arthropathy, status post anterior cruciate ligament (ACL) repair; and right shoulder arthropathy. The request is for diagnostic facet injection, bilaterally at L3-4, L4-5, and L5-S1.

The Official Disability Guidelines (ODG) limit facet injections to two levels, and specifically states facet injections are not appropriate if there is a diagnosis of radiculopathy. The medical records provided for review indicate a diagnosis of multilevel lumbago with bilateral radiculopathy. The diagnostic facet injection, bilaterally at L3-4, L4-5, and L5-S1 **is not medically necessary and appropriate.**

**2) Regarding the request for the Exalgo ER 16mg #150:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not base their decision on any evidence basis. The provider did not dispute the lack of evidence basis used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 88-89, which is part of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 2/25/2002. The medical records provided for review indicate diagnoses of multilevel lumbago with bilateral radiculopathy; status post spinal cord stimulator (SCS) implant; SI joint and facet arthropathy; myofascial syndrome; reactive sleep disturbance; depression; anxiety; left knee arthropathy, status post anterior cruciate ligament (ACL) repair; and right shoulder arthropathy. The request is for Exalgo ER 16mg #150.

The MTUS Chronic Pain guidelines require the documentation of decreased pain and/or functional improvement for the long-term use of opioids. The medical record from 4/25/13 documents a flare-up in pain levels, and the medical report of 6/7/13 documents a drop in those pain levels, and a discontinuance of the 12mg Exalgo ER. The MTUS criteria for continuation of the Exalgo ER 16mg #150 have been met. The Exalgo ER 16mg #150 **is medically necessary and appropriate.**

### 3) Regarding the request for the Fentora 400 mg #84:

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 47, 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 guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance, and additionally utilized the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 11, 88-89, which is part of the Medical Treatment Utilization Schedule (MTUS) as relevant and appropriate for the issue at dispute.

#### Rationale for the Decision:

The employee sustained a work-related injury on 2/25/2002. The medical records provided for review indicate diagnoses of multilevel lumbago with bilateral radiculopathy; status post spinal cord stimulator (SCS) implant; SI joint and facet arthropathy; myofascial syndrome; reactive sleep disturbance; depression; anxiety; left knee arthropathy, status post anterior cruciate ligament (ACL) repair; and right shoulder arthropathy. The request is for Fentora 400mg #84.

The MTUS Chronic Pain guidelines do state that the requested Fentora, an opioid, has been approved by the FDA to treat cancer pain and that it is not recommended for musculoskeletal pain. However, the guidelines also refer the reader to the Opioids section. The medical records reviewed show long-term use of Fentora since August 2012, apparently from tolerance to hydromorphone. The 6/7/13 report documents a decrease in pain levels due to the current medication regimen. MTUS criteria for a satisfactory response to pain medication have been met. The Fentora 400mg #84 **is medically necessary and appropriate.**

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

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), pg.63-64, 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 guidelines used by the Claims Administrator applicable and relevant for the employee's clinical circumstance, and additionally utilized the Chronic Pain Medical Treatment Guidelines (May, 2009), pg.11, 8, which is part of the MTUS, as applicable and relevant to the issue at dispute.

#### Rationale for the Decision:

The employee sustained a work-related injury on 2/25/2002. The medical records provided for review indicate diagnoses of multilevel lumbago with bilateral radiculopathy; status post spinal cord stimulator (SCS) implant; SI joint

and facet arthropathy; myofascial syndrome; reactive sleep disturbance; depression; anxiety; left knee arthropathy, status post anterior cruciate ligament (ACL) repair; and right shoulder arthropathy. The request is for Baclofen 10mg #120.

MTUS Chronic Pain guidelines state muscle relaxants can be a treatment for acute exacerbation of chronic low back pain. MTUS does not specifically address the long-term use of Baclofen; however, MTUS does state the treating physician is required to use clinical judgment in selecting the treatment, frequency, and duration of medication usage. The medical report of 6/7/13 indicates the Baclofen is to be used on an as-needed basis at night for muscle spasms which is consistent with MTUS guidelines. The Baclofen 10mg #120 **is medically necessary and appropriate.**

**5) Regarding the request for the Flexeril 10mg #180:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 41-42, 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 guidelines used by the Claims Administrator applicable and relevant for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 2/25/2002. The medical records provided for review indicate diagnoses of multilevel lumbago with bilateral radiculopathy; status post spinal cord stimulator (SCS) implant; SI joint and facet arthropathy; myofascial syndrome; reactive sleep disturbance; depression; anxiety; left knee arthropathy, status post anterior cruciate ligament (ACL) repair; and right shoulder arthropathy. The request is for Flexeril 10mg #180.

MTUS Chronic Pain guidelines specifically state Flexeril (cyclobenzaprine) is not recommended for chronic use. Records provided for review show Flexeril being prescribed since 5/24/12. The request for Flexeril 10mg #180 **is not medically necessary and appropriate.**

**6) Regarding the request for Klonopin 1 mg #30:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Pain (Chronic), 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 based his/her decision on the

Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 24, which is part of the Medical Treatment Utilization Schedule (MTUS) as relevant and appropriate for the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 2/25/2002. The medical records provided for review indicate diagnoses of multilevel lumbago with bilateral radiculopathy; status post spinal cord stimulator (SCS) implant; SI joint and facet arthropathy; myofascial syndrome; reactive sleep disturbance; depression; anxiety; left knee arthropathy, status post anterior cruciate ligament (ACL) repair; and right shoulder arthropathy. The request is for Klonopin 1mg #30.

MTUS Chronic Pain guidelines specifically states benzodiazepines are not recommended for long-term use. Klonopin is in the benzodiazepine class. The medical records provided for review indicate Klonopin has been prescribed since August of 2012. The request for Klonopin 1mg #30 **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;

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

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

/dl

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.