

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: **11/25/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/2/2013
Date of Injury:	9/30/2008
IMR Application Received:	7/12/2013
MAXIMUS Case Number:	CM13-0001271

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Soma 350mg** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #180** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Neurontin 300mg #90** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Zanaflex 4mg #90** is not **medically necessary and appropriate**.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/12/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/16/2013. 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 **Soma 350mg** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #180** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Neurontin 300mg #90** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Zanaflex 4mg #90** 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 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 patient is a 49 year old female with a date of injury of 9/30/2008. Under consideration are requests for 1 prescription of Norco 10/325mg #180, 1 prescription of Soma 350mg, 1 prescription of Neurontin 300mg #90, and 1 prescription of Zanaflex 4mg #90.

"According to available documentation the patient was under treatment for chronic low back pain with radiation across the bilateral buttocks and groin. The patient denied pain going to the lower extremities. Per the evaluation dated 5/9/13 the patient relevant objective findings included lumbar spine tenderness from L3-L5 bilaterally, bilateral lumbar facet tenderness from L3-S1, worsened lumbar spine pain with extension, side bending, and rotation of the spine, limited lumbar range of motion, and normal neurological examination. The patient was diagnosed with lumbar spondylosis without myelopathy, bilateral lumbar facet syndrome, mechanical low back pain., status post diagnostic lumbar facet injection with positive results, and failed conservative therapies for pain control. Prior lumbar MRI revealed mild disc desiccation at T12-L1, L1-2, L2-3, L3-4, and L4-5, Schmorl's node versus old compression fracture at L1-2, L2-3 mild facet degenerative changes, ligamentum flavum hypertrophy, left-sided pars defect, L3-4 mild 2mm broad based posterior disc bulge indenting anterior thecal sac, mild facet degenerative changes, ligamentum flavum hypertrophy, L4-5 mild bilateral facet

degenerative changes, ligamentum flavum hypertrophy, 2mm broad based disc bulge, moderate spinal stenosis, and mild bilateral-lateral recess narrowing. Recent treatment had included a home exercise program, bed rest, activity modification, ice and heat, physical therapy, chiropractic treatment, TENS, acupuncture, medication management, epidural injections, lumbar interbody fusion, and diagnostic bilateral facet injections. Facet injections produced 70-75% pain relief lasting 2-4 days."

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 Soma 350mg:

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 the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate Soma or carisoprodol, a muscle relaxant, is not indicated for long-term use, can be habit forming, and can augment the sedating effects of other drugs. It is further noted that the employee has failed to clearly profit from prior usage of Soma, and remains off work, on total temporary disability, and has failed to diminish reliance on medical treatment. The employee is consulting multiple providers and receiving multiple procedures. The request is non-certified on the grounds that there is no evidence of functional improvement with prior usage of Soma. **The request for Soma 350mg is not medically necessary and appropriate.**

2) Regarding the request for Norco 10/325mg #180 :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate the criteria for continuation of opioid therapy include evidence of improved functioning and pain and/or successful return to work through usage of opioid analgesic. In this case, the employee does not appear to meet any of the aforementioned criteria. The employee remains off work, and did not clearly exhibit reduction in pain and/or improved performance of activities of daily living through prior usage of Norco. **The request for Norco 10/325mg #180 is not medically necessary and appropriate.**

3) Regarding the request for Neurontin 300mg #90 :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

Rationale for the Decision:

While Neurontin or gabapentin, an anticonvulsant medication, is endorsed as a first-line treatment by the MTUS for chronic pain, particularly that of a neuropathic etiology, in this case, the applicant has used this particular medication chronically and failed to demonstrate any clear evidence of functional improvement following completion of the same. The employee has failed to return to work, improve performance of activities of daily living, and/or diminish reliance on medical treatment. As noted in the MTUS Chronic Pain Medical Treatment Guidelines, page 19, a change in or combination of therapy is endorsed if there is no improvement following an eight-week trial of Neurontin. In this case, there is no evidence of improvement, for all of the reasons stated above. **The request for Neurontin 300mg #90 is not medically necessary and appropriate.**

4) Regarding the request for Zanaflex 4mg #90 :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate antispasticity drugs topic, tizanidine or Zanaflex is endorsed by the MTUS for off label use in the treatment of back pain, although it is specifically FDA approved only in the management of spasticity, which is not present here. In this case, however, as with the other drugs, there is no evidence of functional improvement through prior usage of Zanaflex or tizanidine. The employee has failed to return to work, remains highly reliant on other medical treatments, and has failed to demonstrate any improved performance of activities of daily living through prior usage of Zanaflex and/or other medications. The guideline criteria have not been met. **The request for Zanaflex 4mg #90 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

/ldh

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.