
Notice of Independent Medical Review Determination

Dated: 9/30/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/12/2013
Date of Injury: 4/8/2008
IMR Application Received: 7/19/2013
MAXIMUS Case Number: CM13-0001994

- 1) MAXIMUS Federal Services, Inc. has determined the request for gabapentin 300mg #100, 1 three times a day, with one refill **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for ibuprofen 800mg #100, 1 twice a day, with one refill **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm patches 1 box, apply cut patch to arm 10 hours a day, with two refills **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 gabapentin 300mg #100, 1 three times a day, with one refill **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for ibuprofen 800mg #100, 1 twice a day, with one refill **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm patches 1 box, apply cut patch to arm 10 hours a day, with two refills **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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 12, 2013:

History of Condition:

This is a 49-year-old female with a 4/8/2008 date of injury; she was injured when she was carrying about 30 or so items on hangers to go back onto the floor that had been tried on by customers. 7/3/13 progress report indicates persistent pain complaints. Physical exam demonstrates some hand numbness. Treatment to date has included physical therapy, occupational therapy, splints, TENS unit, inpatient alcohol detox, cervical ESI, and medication.

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 (date 07/19/2013)
- Utilization Review by [REDACTED] (dated 07/19/2013)
- Medical records from Employee/Representative (dated 07/19/2013)
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for gabapentin 300mg #100, 1 three times a day, with one refill:

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, (2009), Antiepilepsy drugs (AEDs), pages 16-17 and Gabapentin (Neurontin®), page 49, 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, (2009), Specific Anti-epilepsy Drugs, Gabapentin, pages 18-19, part of the MTUS, and the Section 9792.20(f), Functional improvement, of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 4/08/08. The submitted and reviewed medical records note pain radiating along the inner aspect of the left arm, forearm and hand. Prior treatment included surgery, medications, TENS unit, and injections. The records reviewed indicate diagnoses include chronic pain syndrome, left ulnar neuritis and chronic neuropathic pain left upper extremity, left cervical radiculopathy associated with foraminal stenosis at C6 and chronic pain syndrome with associated psychological factors, including depression and alcohol use. A request has been submitted for gabapentin 300mg #100, 1 three times a day, with one refill.

MTUS Chronic Pain Guidelines, endorse gabapentin in the treatment of neuropathic pain and/or chronic regional pain syndrome, indicated in this case. However, the guidelines note that demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continued treatment. The records reviewed indicate the employee has used gabapentin chronically, has failed to derive any lasting benefit or functional improvement, and has failed to return to work. The records do not indicate evidence of analgesia, improved performance of activities of daily living, and/or diminished reliance on medical treatment through prior usage of gabapentin. The guidelines do not support the requested medication in this case. The request for gabapentin 300mg #100, 1 three times a day, with one refill **is not medically necessary and appropriate.**

2) Regarding the request for ibuprofen 800mg #100, 1 twice a day, with one refill:

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, (2009), NSAIDs, page 67, part of the Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG), (current edition), Pain chapter, NSAIDs, a medical treatment guideline not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, (2009), page 22, part of the MTUS, and Section 9792.20(f),

Functional improvement, of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 4/08/08. The submitted and reviewed medical records note pain radiating along the inner aspect of the left arm, forearm and hand. Prior treatment included surgery, medications, TENS unit, and injections. The records reviewed indicate diagnoses include chronic pain syndrome, left ulnar neuritis and chronic neuropathic pain left upper extremity, left cervical radiculopathy associated with foraminal stenosis at C6 and chronic pain syndrome with associated psychological factors, including depression and alcohol use. A request has been submitted for ibuprofen 800mg #100, 1 twice a day, with one refill.

MTUS Chronic Pain Medical Treatment Guidelines consider anti-inflammatory medications (ibuprofen) the traditional first-line of treatment but note that demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continued treatment. In this case, the reviewed medical records do not document functional improvement through prior usage of ibuprofen. The employee has failed to return to work and the records do not document a reduction in dependence on medical treatment, improved performance of activities of daily living, and/or reduction in work restrictions. The records indicate alcohol and illicit drug abuse. Continued use of this medication is not supported by the guidelines. The request for ibuprofen 800mg #100, 1 twice a day, with one refill **is not medically necessary and appropriate.**

3) Regarding the request for Lidoderm patches 1 box, apply cut patch to arm 10 hours a day, with two refills:

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, (2009), pages 56-57, 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 Section 9792.20(f), Functional improvement, of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 4/08/08. The submitted and reviewed medical records note pain radiating along the inner aspect of the left arm, forearm and hand. Prior treatment included surgery, medications, TENS unit, and injections. The records reviewed indicate diagnoses include chronic pain syndrome, left ulnar neuritis and chronic neuropathic pain left upper extremity, left cervical radiculopathy associated with foraminal stenosis at C6 and chronic pain syndrome with associated psychological factors, including

depression and alcohol use. A request has been submitted for Lidoderm patches 1 box, apply cut patch to arm 10 hours a day, with two refills.

The MTUS Chronic Pain guidelines note that demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continued treatment. The submitted records do not exhibit evidence of functional improvement through use of Lidoderm. The records reviewed indicate the employee has failed to diminish reliance on medical treatment and has failed to diminish the usage of illicit drugs and alcohol. The guidelines do not support Lidoderm in this case. The request for Lidoderm patches 1 box, apply cut patch to arm 10 hours a day, with two refills **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, 18th Floor
Oakland, CA 94612

/srb

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.