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## Notice of Independent Medical Review Determination

Dated: 10/3/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/11/2013
Date of Injury:	8/29/2011
IMR Application Received:	7/22/2013
MAXIMUS Case Number:	CM13-0002517

- 1) MAXIMUS Federal Services, Inc. has determined the request for a lumbar epidural steroid injection at L5-S1 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Norco 10/325mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Gabapentin 600mg **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Anaprox 550mg **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Cyclobenzaprine 7.5mg **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Venlafaxine ER 75mg **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 a lumbar epidural steroid injection at L5-S1 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Norco 10/325mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Gabapentin 600mg **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Anaprox 550mg **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Cyclobenzaprine 7.5mg **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Venlafaxine ER 75mg **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 Preventive Medicine and 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 11, 2013:

“The patient is a 44-year-old male with a date of industrial injury of 08/29/11. The operative report dated 02/19/13 indicates the patient underwent bilateral L3, L4, L5 median branch nerve blocks. The operative report dated 05/14/13 indicates the patient underwent radiofrequency ablation of bilateral L3, L4, L5 median branch nerves. The patient was seen by Dr. [REDACTED] on 05/28/13, at which time he reported 0% reduction in pain since his radiofrequency ablation procedure on 05/14/13. He reported his pain at level 8/10 and stated his pain was unchanged. He still reported insomnia and

relies on pain medication daily. Also per the 05/28/13 report, the patient reported he feels more pain while sitting and less pain when standing and that the pain is associated with weakness. He reported the pain decreases with medications, doing exercises and standing and walking for a short time. He reported the pain in his back is 100% of his pain. Objective findings per the 05/28/13 report were noted as forward flexion of the lumbar spine to 60 degrees and extension to 10 degrees. There was tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms and mention of sciatic notch tenderness. There was positive facet loading maneuver bilaterally and negative straight leg raise bilaterally in seated and supine. Examination of the hip revealed point tenderness to palpation over the greater trochanter bilaterally consistent with trochanteric bursitis. Motor strength was noted as 5/5 and symmetric throughout the bilateral upper and lower extremities with the exception of bilateral great toe extension which was 4+ / 5. Sensation was noted as intact to light touch throughout the upper and lower extremities. Deep tendon reflexes were normal with mention that reflexes were symmetric at 2+/4 in the bilateral lower extremities. There was mention of positive Hoffman's sign on the left and negative Babinski's test and negative clonus sign. The assessment was lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy and lumbago. The treatment plan included prescriptions for Norco, Gabapentin, Anaprox, Omeprazole, Cyclobenzaprine, and Venlafaxine (Effexor). The patient returned to Dr. [REDACTED] y on 07/02/13, at which time it was noted the patient still reported 0% reduction of pain from his radiofrequency ablation performed on 05/14/13. He reported pain was unchanged at 8/10 and he still reported insomnia. The remainder of the subjective complaints was the same as the 05/28/13 report. Objective findings on 07/02/13 noted forward flexion of the lumbar spine to 50 degrees and extension to 10 degrees. There was tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms and mention of sciatic notch tenderness. There was positive facet loading maneuver bilaterally and negative straight leg raise bilaterally in seated and supine. Examination of the hip revealed point tenderness to palpation over the greater trochanter bilaterally consistent with trochanteric bursitis. Motor strength was noted as 5/5 and symmetric throughout the bilateral upper and lower extremities with the exception of bilateral great toe extension which was 4+ / 5. Sensation was noted as decreased over the S1 distribution left more than right. Deep tendon reflexes were normal with mention that reflexes were symmetric at 2+ 14 in the bilateral lower extremities. There was mention of positive Hoffman's sign on the left and negative Babinski's test and negative clonus sign. The assessment was lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy and lumbago. The treatment plan included lumbar epidural steroid injection, and prescriptions for Norco, Gabapentin, Anaprox, Omeprazole, Cyclobenzaprine, and Venlafaxine (Effexor)."

#### **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 7/22/13)
- Utilization Review Determination from [REDACTED] (dated 7/11/13)
- Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for a lumbar epidural steroid injection at 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 Chronic Pain Medical Treatment Guidelines, 2009, ESI Treatments section, 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.

Rationale for the Decision:

The employee sustained an industrial injury on 8/29/2011 and has experienced back pain that is exacerbated by standing, sitting and walking. The employee's diagnoses include lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy and lumbago. Prior treatment has included medications, injections, bilateral L3, L4 and L5 median branch nerve blocks and radiofrequency ablation of bilateral L3, L4 and L5 median branch nerves. A request has been submitted for a lumbar epidural steroid injection at L5-S1.

The MTUS Chronic Pain Guidelines note that for epidural steroid injections, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The submitted medical records indicate radiculopathy with positive straight leg raises and decreased sensation left more than right at S1. There is also an MRI which shows L5-S1 disc herniation. The request for a lumbar epidural steroid injection at L5-S1 is **medically necessary and appropriate.**

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

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

The Claims Administrator based its decision on Chronic Pain Medical Treatment Guidelines, (2009), page 80, 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.

Rationale for the Decision:

The employee sustained an industrial injury on 8/29/2011 and has experienced back pain that is exacerbated by standing, sitting and walking. The employee's diagnoses include lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy and lumbago. Prior treatment has included medications, injections, bilateral L3, L4 and L5 median branch nerve blocks and radiofrequency ablation of bilateral L3, L4 and L5 median branch nerves. A request has been submitted for Norco 10/325mg.

The MTUS Chronic Pain Guidelines for opioids recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Per the guidelines, satisfactory response to treatment may be indicated by decreased pain, increased level of function or improved quality of life. The submitted medical records do not document the use of Norco and how this medication has improved function or decreased pain. The request for Norco 10/325mg **is not medically necessary and appropriate.**

**3) Regarding the request for Gabapentin 600mg:**

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

The Claims Administrator based its decision on Chronic Pain Medical Treatment Guidelines, (2009), page 16, which is part of the California 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.

Rationale for the Decision:

The employee sustained an industrial injury on 8/29/2011 and has experienced back pain that is exacerbated by standing, sitting and walking. The employee's diagnoses include lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy and lumbago. Prior treatment has included medications, injections, bilateral L3, L4 and L5 median branch nerve blocks and radiofrequency ablation of bilateral L3, L4 and L5 median branch nerves. A request has been submitted for Gabapentin 600mg.

The MTUS Chronic Pain Guidelines note that anti-epilepsy drugs may be used for neuropathic pain. However, based upon the submitted medical records, there is no documentation that the employee's pain is neuropathic. Additionally, there is no documentation of the efficacy of this medication after it has been used. The request for Gabapentin 600mg **is not medically necessary and appropriate.**

**4) Regarding the request for Anaprox 550mg:**

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), page 22, which is part of the California 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.

Rationale for the Decision:

The employee sustained an industrial injury on 8/29/2011 and has experienced back pain that is exacerbated by standing, sitting and walking. The employee's diagnoses include lumbosacral spondylosis without myelopathy, displacement of

lumbar intervertebral disc without myelopathy and lumbago. Prior treatment has included medications, injections, bilateral L3, L4 and L5 median branch nerve blocks and radiofrequency ablation of bilateral L3, L4 and L5 median branch nerves. A request has been submitted for Anaprox 550mg.

The MTUS Chronic Pain Guidelines note that non-steroidal anti-inflammatory medications can help with chronic back pain. However, the guidelines do not recommend long-term use. The submitted medical records indicate that this medication has been prescribed for several months, with no evidence of efficacy. The request for Anaprox 550mg **is not medically necessary and appropriate.**

#### 5) Regarding the request for Omeprazole 20mg:

##### 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), Prilosec section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, (2009), page 68, which is part of the MTUS.

##### Rationale for the Decision:

The employee sustained an industrial injury on 8/29/2011 and has experienced back pain that is exacerbated by standing, sitting and walking. The employee's diagnoses include lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy and lumbago. Prior treatment has included medications, injections, bilateral L3, L4 and L5 median branch nerve blocks and radiofrequency ablation of bilateral L3, L4 and L5 median branch nerves. A request has been submitted for Omeprazole 20mg.

The MTUS Chronic Pain Guidelines note that clinicians should weigh the indications for non-steroidal anti-inflammatory drugs against both gastrointestinal and cardiovascular risk factors. The submitted medical records do not indicate gastrointestinal symptoms or demonstrate that the employee is at high risk for gastrointestinal symptoms. Based upon the submitted medical records, the employee may use nonsteroidal anti-inflammatory medications without protective proton pump inhibitors. The request for Omeprazole 20mg **is not medically necessary and appropriate.**

#### 6) Regarding the request for Cyclobenzaprine 7.5mg:

##### 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), which is part of the California Medical Treatment Utilization Schedule (MTUS), but did not cite a specific section. The provider did not dispute the guidelines used by the Claims Administrator. The Expert

Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), page 14, which is part of the MTUS.

Rationale for the Decision:

The employee sustained an industrial injury on 8/29/2011 and has experienced back pain that is exacerbated by standing, sitting and walking. The employee's diagnoses include lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy and lumbago. Prior treatment has included medications, injections, bilateral L3, L4 and L5 median branch nerve blocks and radiofrequency ablation of bilateral L3, L4 and L5 median branch nerves. A request has been submitted for Cyclobenzaprine 7.5mg.

The MTUS Chronic Pain Guidelines note that this medication is recommended for a short course of therapy, with shown efficacy. The submitted medical records do not document decreased spasm or reduced pain. Additionally, the submitted medical records noted that this medication has been used longer than the recommended duration. The request for Cyclobenzaprine 7.5mg **is not medically necessary and appropriate.**

**7) Regarding the request for Venlafaxine ER 75mg:**

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), 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.

Rationale for the Decision:

The employee sustained an industrial injury on 8/29/2011 and has experienced back pain that is exacerbated by standing, sitting and walking. The employee's diagnoses include lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy and lumbago. Prior treatment has included medications, injections, bilateral L3, L4 and L5 median branch nerve blocks and radiofrequency ablation of bilateral L3, L4 and L5 median branch nerves. A request has been submitted for Venlafaxine ER 75mg.

The MTUS Chronic Pain Guidelines note that Venlafaxine is recommended for neuropathic pain or for patients with pain with depression. The submitted medical records do not establish the diagnosis of depression. Additionally, the submitted medical records do not document neuropathic pain. The guidelines do not support the requested medication in this setting. The request for Venlafaxine ER 75mg **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

/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.