

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **11/22/2013**

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/3/2013
Date of Injury: 10/3/2010
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003399

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Soma /carisprodol 350mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Lorcet/hydrocodone APAP 10/650mg #120 is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Neurontin/gabapentin 300mg #90 is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Protonix/pantoprazole 20mg #60 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 retrospective request for **Soma /carisprodol, 350mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Lorcet/hydrocodone APAP 10/650mg #120 is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Neurontin/gabapentin 300mg #90 is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Protonix/pantoprazole 20mg #60 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.

CLINICAL SUMMARY:

The patient is a 47 year old male with a date of injury of October 3, 2010. The provider is requesting retrospective certification of prescriptions that were dispensed on June 4, 2013. The patient has been treated for chronic neck pain with radiating pain to the upper extremities, as well as low back pain with radiation to the lower extremities. The patient has limited range of motion, with moderate muscle spasm and tenderness of cervical and lumbar spine. Prior treatment consisted of rehabilitation therapies, chiropractic care, home exercise program, medication, anterior cervical discectomy and fusion at C5-C7. The report in which medication was requested dated 6/4/2013 states the patient still has persistent neck pain with radiculopathy, has severe gastrointestinal irritation with current pain medications, and states the patient has spasms in his neck. His pain rating is 5-6/10 on the pain scale.

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 retrospective request for Soma /carisprodol, 350mg #60:

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, Muscle Relaxants, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 29, which is a part of MTUS.

Rationale for the Decision:

CA MTUS chronic pain guidelines page 29 states use of Soma/Carisoprodol is not recommended. The medication especially when combined with hydrocone has abuse potential and may have an effect similar to heroin. There is abuse potential due to sedative and relaxant effects. **The retrospective request for 60 doses of Soma/carisprodol is not medically necessary and appropriate.**

2) Regarding the retrospective request for Lorcet/hydrocodone APAP 10/650mg #120:

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 the Official Disability Guidelines, Neck and Upper Back, which is not a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 80 and 91, which are a part of MTUS.

Rationale for the Decision:

CA MTUS chronic pain guidelines page 91 states that Lorcet dosing every 6 hours is appropriate. The guidelines on page 80 also state that opioids should be continued when the patient has returned to work or when the patient has improving pain and function. Even though the treating physician did not document this improvement, it was documented in the AME report that the employee had improved function and decreased pain with the opioids. There is no evidence that the medication is being abused. **The retrospective request for Lorcet/hydrocodone APAP 10/650mg #120 is medically necessary and appropriate.**

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

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 are a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 18-19, which are a part of MTUS.

Rationale for the Decision:

CA MTUS chronic pain guidelines describe neuropathic pain. Neuropathic pain is characterized by symptoms such as lancinating, electric shock-like, paroxysmal, tingling, numbing, and burning sensations that are distinct from nociceptive pain. The employee's radiculopathy qualifies as neuropathic pain. As stated in the AME report the employee had had a 3.5/10 pain level from a 9/10 pain level. This is more than the 50% reduction in pain that the guidelines recommend for continuation of AED medication such as gabapentin. Therefore with the reduction in pain, the request for gabapentin is medically appropriate. **The retrospective request for Neurontin/gabapentin 300mg #90 is medically necessary and appropriate.**

4) Regarding the retrospective request for Protonix/pantoprazole 20mg #60:

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 are a part of MTUS.

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

Rationale for the Decision:

CA MTUS chronic pain guidelines state that PPI are indicated in patients with risk of gastrointestinal events. The risk factors include (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The employee does not meet any of these criteria. There is no indication that the employee is at risk of gastric ulcer or irritation and there is no specific indication of where the GI irritation is located. **The retrospective request for Protonix/pantoprazole 20mg #60 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

/dso

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.