MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 11/4/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/10/2013
Date of Injury:	9/12/2009
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004462

1) MAXIMUS Federal Services, Inc. has determined the retrospective request for Naproxen sodium tablets 550mg #120 **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the retrospective request for Omeprazole delayed-release capsules 20mg #120 **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the retrospective request for Ondansetron ODT tablets 8mg #30 x 2 #60 **is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the retrospective request for Cyclobenzaprine Hydrochloride tablets 7.5mg #120 **is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the retrospective request for Sumatriptan Succinate tablets 25mg #9 x 2 #18 **is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the retrospective request for Medrox pain relief ointment 120gm #240 **is not medically necessary and appropriate.**

7) MAXIMUS Federal Services, Inc. has determined the retrospective request for Tramadol Hydrochloride ER 150mg #90 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/9/2013. 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 Naproxen sodium tablets 550mg #120 **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the retrospective request for Omeprazole delayed-release capsules 20mg #120 **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the retrospective request for Ondansetron ODT tablets 8mg #30 x 2 #60 **is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the retrospective request for Cyclobenzaprine Hydrochloride tablets 7.5mg #120 **is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the retrospective request for Sumatriptan Succinate tablets 25mg #9 x 2 #18 **is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the retrospective request for Medrox pain relief ointment 120gm #240 **is not medically necessary and appropriate.**

7) MAXIMUS Federal Services, Inc. has determined the retrospective request for Tramadol Hydrochloride ER 150mg #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 Physical Medicine and Rehabilitation and Pain Management 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 50-year-old male who reported a work-related injury on 09/12/2009 as the result of a strain to the cervical and lumbar spines. The patient subsequently presents for treatment for the following diagnoses: cervical discopathy, right shoulder impingement syndrome, lumbar discopathy with left lower extremity radiculitis and rule out internal derangement at the right knee. The clinical note dated 05/29/2013 is the most recent examination of the patient, under the care of the primary treating provider Dr. [redacted]. The provider documented that the patient presents with continued residual symptomatology to the lumbar spine, cervical spine and right knee. The provider documents that the patient has been having significant increasing pain complaints. The patient reported headaches that are migrainous in nature, associated with periods of increased pain to the cervical spine. The patient reported nausea complaints that are not alleviated by Prilosec. The provider documented that the patient additionally reported complaints of nausea with the use of naproxen. The provider reported that physical exam of the patient revealed tenderness at the cervical paravertebral muscles, tenderness at the acromioclavicular joint and tenderness at the lumbar paravertebral muscles with spasms. The provider documented that the patient was administered an IM injection of 2 cc's of Toradol as well as vitamin B12. The provider requested a referral for the patient to undergo a lumbar epidural steroid injection, updated imaging of the cervical and lumbar spines and electrodiagnostic studies.

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** Naproxen sodium tablets 550mg #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 Chronic Pain Medical Treatment Guidelines, NSAIDs, which is part of the California Medical Treatment Utilization Schedule (MTUS).

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Naproxen, pg. 73, which is part of the California Medical Treatment Utilization Schedule (MTUS).

   Rationale for the Decision:
   Chronic Pain Medical Treatment Guidelines indicate that anti-inflammatories are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. The most recent clinical documentation submitted for review is dated from 05/2013. The employee has been utilizing this medication

chronically in nature. The clinical notes lack evidence of a recent assessment of the employee's pain complaints as well as the efficacy of his medication regimen as documented by an increase in objective functionality and a decrease in rate of pain on a specific VAS. **The retrospective request for Naproxen sodium tablet 550mg #120 is not medically necessary and appropriate.**

2) **Regarding the retrospective request for** Omeprazole delayed-release capsules 20mg #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 Chronic Pain Medical Treatment Guidelines, NSAIDs, which is part of the California Medical Treatment Utilization Schedule (MTUS).

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 68-69, which are part of the California Medical Treatment Utilization Schedule (MTUS).

   Rationale for the Decision:
   There is a lack of documentation evidencing the employee's reports of efficacy with the use of this medication for his gastrointestinal complaints. The provider documents that the employee has found symptomatic relief of acid reflux and GI upset that occurred with the use of naproxen. However, the most recent clinical note assessing the employee's current condition is dated from over 90 days. Given the lack of recent documentation of the employee's reports of efficacy with his medication regimen, the request for omeprazole delayed release capsules 20 mg #120 is non-certified. **The retrospective request for Omeprazole delayed-release capsules 20mg #120 is not medically necessary and appropriate.**

3) **Regarding the retrospective request for** Ondansetron ODT tablets 8mg #30 x 2 #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 ODG-TWC Pain Procedure Summary, which is a Medical Treatment Guideline (MTG) that is not part of the California Medical Treatment Utilization Schedule (MTUS), and Mosby's Drug Consult, which is not part of the MTUS.

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antiemetics, Promethazine and Ondansetron (Zofran) sections, which are part of the California Medical Treatment Utilization Schedule (MTUS).

   Rationale for the Decision:
   The Chronic Pain Medical Treatment Guidelines state Ondansteron is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use and is FDA-approved acute treatment for

gastroenteritis. The clinical notes lack evidence of a recent assessment of the employee's symptomatology as the most recent clinical note is dated from 05/2013. Specific documentation of nausea or vomiting and the frequency of symptoms was not evidenced in the clinical notes reviewed to support the current request. **The retrospective request for Ondansetron ODT tablets 8mg #30 x 2 #60 is not medically necessary and appropriate.**

4) **Regarding the retrospective request for** Cyclobenzaprine Hydrochloride tablets 7.5mg #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 Chronic Pain Medical Treatment Guidelines, Muscle Relaxants, and Antispasticity Drugs sections, which are part of the California Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines (ODG), Pain Chapter, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine (Flexeril), pg. 41-42, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:
Chronic Pain Medical Treatment Guidelines indicate Cyclobenzaprine is recommended as an option using a short course of therapy. The provider documents in the clinical note dated from 05/2013 that the employee has utilized cyclobenzaprine chronically in nature; however, the provider documented that the employee was aware that this medication should only be taken in short courses for acute spasms. The provider prescribed the employee 120 tablets. The clinical notes evidence that the employee has utilized this medication for longer than a short course of therapy. **The retrospective request for Cyclobenzaprine Hydrochloride tablets 7.5mg #120 is not medically necessary and appropriate.**

5) **Regarding the retrospective request for** Sumatriptan Succinate tablets 25mg #9 x 2 #18**:**

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 ODG-TWC Head Procedure Summary, which is a Medical Treatment Guideline (MTG) that is not part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Triptans.

Rationale for the Decision:
Official Disability Guidelines state triptans are recommended for migraine sufferers. The clinical notes lacked evidence of measurable subjective and/or functional benefit as a result of the employee utilizing this medicine for pain complaints as a result of migraines. The clinical notes did not indicate how frequently the employee has headaches. The provider documented generalized statements about the employee's reports of efficacy, documenting that the employee found relief from this medication, allowing for a higher level of function during the day and allowing to maintain usual work and non-work activity levels. Quantifiable evidence of the employee's reports of efficacy objectively was not noted. **The retrospective request for Sumatriptan Succinate tablets 25mg #9 x 2 #18 is not medically necessary and appropriate.**

6) **Regarding the retrospective request for** Medrox pain relief ointment 120gm #240 **:**

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 (2009), Topical Analgesics and NSAIDs sections, which is part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, pages 111, 105, 113.

Rationale for the Decision:
Chronic Pain Medical Treatment Guidelines indicate topical analgesics are largely experimental in use, with few randomized controlled trials to determine efficacy or safety. Medrox ingredients include Menthol, Methyl Salicylate and Capsaicin. Guidelines recommend the use of salicylate topical and indicate Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. The clinical notes lacked evidence of a recent assessment of the employee's condition to support the true efficacy of this intervention for the employee's pain complaints. **The retrospective request for Medrox pain relief ointment 120gm #240 is not medically necessary and appropriate.**

7) **Regarding the retrospective request for**Tramadol Hydrochloride ER 150mg #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 (2009), Opioids, which is part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 78, 93-94, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:
Chronic Pain Medical Treatment Guidelines indicate 4 domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the '4 A′s' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Clinical notes lack evidence of a current assessment of the employee's condition. **The retrospective request for Tramadol Hydrochloride ER 150mg #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.