

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/26/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	3/27/2009
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0004769

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg, 1 q 6 hours, PRN #120 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Neurontin 600 mg, 1 q HS #30 is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Transdermal compounded cream: Fluriprofen 20%, Tramadol 20%, Cyclobenzaprine 20% is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol 20% Cyclobenzaprine 20% is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/12/2013. 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 **Norco 10/325mg, 1 q 6 hours, PRN #120 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Neurontin 600 mg, 1 q HS #30 is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Transdermal compounded cream: Fluriprofen 20%, Tramadol 20%, Cyclobenzaprine 20% is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol 20% Cyclobenzaprine 20% 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 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 has a date of injury 3/27/2009. Diagnosis includes sacroiliitis, lumbar decompression laminectomy and fusion 5/2/2013, lumbar post-laminectomy syndrome, other symptoms referable to back. The utilization review denial letter dated 7/22/2013 states that the patient underwent lumbar L4-5 decompression laminectomy and fusion 5/2/2013. The patient has reportedly demonstrated some improvement in gait; however, it has been stated that sufficient time has not passed to determine the nature and extent of the therapeutic benefit obtained from the procedure. The start date for post-operative rehabilitation had not yet been determined.

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 Norco 10/325mg, 1 q 6 hours, PRN #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, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids for Neuropathic Pain, page 82, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain guidelines state that Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). The medical records indicate that the employee has taken Norco and Neurontin for many months due to chronic low back and radicular pain. The employee is status post lumbar L4-5 decompression laminectomy and fusion 5/2/2013. It is reasonable that the employee would continue to need to take Norco in conjunction with Neurontin as the employee has not had a significant reduction of pain post-operatively, thus Norco one tablet every six hours as needed is indicated. **The request for Norco 10/325mg, 1 q 6 hours, PRN #120 is medically necessary and appropriate.**

2) Regarding the request for Neurontin 600 mg, 1 q HS #30:

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 part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Gabapentin, page 18, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain guidelines state that Neurontin has been considered as a first-line treatment for neuropathic pain. The records submitted for review document the employee has chronic neuropathic pain. The employee is status post lumbar L4-5 decompression laminectomy and fusion 5/2/2013. **The request for Neurontin 600 mg, 1 q HS #30 is medically necessary and appropriate.**

3) Regarding the request for Transdermal compounded cream: Fluriprofen 20%, Tramadol 20%, Cyclobenzaprine 20% :

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 part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Creams, pages 111-113, which are part of the MTUS.

Rationale for the Decision:

The Chronic Pain guidelines state that topical analgesics are largely experimental with few randomized controlled trials to determine efficacy or safety. The guidelines do not support topical NSAIDs for osteoarthritic spine, hip or shoulders. The guidelines also do not support topical NSAIDs for neuropathic pain. This employee has a diagnosis of neuropathic pain due to post-laminectomy syndrome, and possibly osteoarthritic spine condition from degenerative disc disease. **The request for transdermal compounded cream: Fluriprofen 20%, Tramadol 20%, Cyclobenzaprine 20% is not medically necessary and appropriate.**

4) Regarding the request for Tramadol 20%, Cyclobenzaprine 20%:

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 part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Creams, pages 111-113, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The records provided for review lack documentation the employee has failed use of oral medications such as anticonvulsants or antidepressants. The medical records do not indicate that the employee is unable to take oral medications. The employee is currently taking Norco as well as Neurontin orally. Further, the guidelines do not recommend muscle relaxants as a topical product. **The request for Tramadol 20%, Cyclobenzaprine 20% 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

/sab

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.