

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

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Dated: 11/7/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	6/28/2013
Date of Injury:	6/12/2002
IMR Application Received:	7/31/2013
MAXIMUS Case Number:	CM13-0005506

- 1) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Norco **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Prilosec **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Neurontin **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Ambien **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Dendracin Lotion **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Ibuprofen **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 6/28/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/14/2013. 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 unknown prescription of Norco **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Prilosec **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Neurontin **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Ambien **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Dendracin Lotion **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of Ibuprofen **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:**

This patient is a 46-year-old male who reported an injury on 06/12/2002. The clinical documentation submitted for review indicates the patient to have a history of low back pain with placement of a spinal cord stimulator. Clinical notes from 04/11/2012 indicate that the patient was prescribed Norco, Neurontin, Omeprazole, Dendracin, and Ambien. Furthermore, notes indicate that the patient was prescribed Celebrex for inflammation; however, clinical notes also indicate that the patient uses other NSAIDs due to guidelines indicate upset. Clinical notes from 06/21/2012 indicate the patient to have chronic pain postoperatively secondary to failed surgery. Clinical notes from 08/22/2012 indicated the patient to have complaints of headache, with radiating symptoms to the neck described as stabbing and throbbing; however, notes indicated the patient continued to receive good benefit and coverage from his spinal cord stimulator. Furthermore, the patient indicated his current pain medication regimen was helping to alleviate his pain. Physical examination of the patient noted mild paravertebral tenderness and positive straight leg raise with decreased range of motion of the lumbar spine with 35 degrees of flexion, 15 degrees extension, and 15 degrees right and left

lateral rotation. On 08/29/2012, the patient underwent a urine drug screen indicating findings consistent with the patient's prescribed medications with the exception that hydrocodone was not detected. Follow up notes on 10/17/2012 indicated the patient to have pain to the low back verbalized as 7/10 VAS, with notes indicating that the patient's depression was improved with decreased pain and that the patient's stimulator continued to provide good coverage and good relief. Notes indicated the patient's pain medication regimen was helping to control pain. Objective clinical findings for the patient remained unchanged from the previous visit. Clinical notes from 12/19/2012 indicated continued pain verbalized as 7/10 VAS with no change in the patient's subjective or objective findings. On 04/24/2013, notes detail no change in the patient's medication regimen which consisted of Norco, Neurontin, Omeprazole, Dendracin lotion, and Ambien. No changes were noted on physical examination, with the patient indicating a pain level of 6/10 VAS with regard to the low back. On 06/19/2013, the patient was evaluated with continued complaint of pain verbalized as 6/10 VAS. Notes indicated the patient's stimulator was still providing good coverage with good relief of pain and that the patient's pain medications were continuing to be beneficial. No changes were noted in the patient's pain medication regimen, with the exception of ibuprofen added for treatment of inflammation. A urine drug screen obtained during this visit was noted to be consistent with the patient's prescribed medications.

#### **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 CID Management
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for unknown prescription of Norco:**

##### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criterias for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Opioids, specific drug list, On-Going Management, pages. 78 & 91, which is a part of MTUS.

##### Rationale for the Decision:

Norco is indicated by the Chronic Pain guidelines as recommended for moderate to moderately severe pain. Furthermore, guidelines indicate the recommendation for the 4 A's for ongoing monitoring of patients on opioid analgesics. These 4 domains are described as monitoring for analgesia, adverse side effects, activities of daily living, and aberrant drug taking behaviors. The documentation submitted for review indicates the employee to have been prescribed Norco since at least 04/11/2012 for treatment of low back complaints in conjunction with other medications as well as a spinal cord stimulator. Notes indicate that the employee has had no change since 04/11/2012 and his physical examination

findings of limited lumbar range of motion with bilateral lateral rotation 15 degrees, extension 15 degrees, and flexion of 35 degrees, as well as mild paravertebral tenderness and positive straight leg raise. Furthermore, notes indicate that the employee states benefit from his medication regimen as provided. The employee has a stated pain scale of 6/10 to 7/10, VAS, with use of the medication. However, while the documentation submitted for review states that the employee receives benefit from the medications, there is a lack of documentation indicating a significant decrease in the patient's pain with the use of Norco. Furthermore, there is a lack of documentation indicating that the employee has increased ability to undertake activities of daily living with the use of Norco, and there is a lack of documentation indicating that adverse side effects of the medication, or risk assessment of the employee for drug related behavior has been addressed. **The request for unknown prescription of Norco is not medically necessary and appropriate.**

**2) Regarding the request for unknown prescription of Prilosec:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criterias for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular disease, page 68, which is part of MTUS, and the Official Disability Guidelines (ODG), which is not part of MTUS.

Rationale for the Decision:

The Chronic Pain guidelines indicate that proton pump inhibitors such as Prilosec are indicated for patients at moderate risk of gastrointestinal events. While the documentation submitted for review indicates that the employee has a prior history of gastrointestinal (GI) upset with the use of NSAIDs, there is no indication in the notes of current GI symptoms of the employee to warrant the use of Prilosec. Furthermore, the documentation submitted for review fails to indicate a prior GI history of the employee to include ulcers, GI bleeding, or gastroesophageal reflux disease. **The request for unknown prescription of Prilosec is not medically necessary and appropriate.**

**3) Regarding the request for unknown prescription of Neurontin:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criterias for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Specific Anti-Epilepsy Drugs, page 18, which is a part of MTUS.

Rationale for the Decision:

Neurontin is indicated by the Chronic Pain guidelines as a first line treatment for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. While the medical records submitted for review indicates that the employee has a history of failed back surgery syndrome, and currently receives coverage from a spinal cord stimulator; as well as findings of a positive straight leg raise, the clinical notes fail to indicate that the employee underwent a comprehensive evaluation of the requesting physician, indicating significant findings of a neuropathology to support the use of Neurontin. **The request for unknown prescription of Neurontin is not medically necessary and appropriate.**

**4) Regarding the request for unknown prescription of Ambien:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criterias for its decision.

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 Official Disability Guidelines (ODG), Pain Chapter, Zolpidem (Ambien®).

Rationale for the Decision:

The California MTUS/ACOEM Guidelines do not specifically address Ambien. The Official Disability Guidelines (ODG) indicate that Ambien is a prescription short acting nonbenzodiazepine hypnotic which is approved for the short-term, usually 2 to 6 weeks, treatment of insomnia. While sleeping pills, so called minor tranquilizers and anti-anxiety agents are commonly prescribed for chronic pain, pain specialists rarely, if ever, recommend them for long-term use. The documentation submitted for review indicates that the employee has been prescribed Ambien since 04/11/2012. However, there was no indication in the notes reviewed that the employee had sleep difficulties. Furthermore, reference is made that the employee felt as though the sleep medications were causing some allergies; however, this was not further addressed in the notes. **The request for unknown prescription of Ambien is not medically necessary and appropriate.**

**5) Regarding the request for unknown prescription of Dendracin Lotion:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criterias for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Topical Analgesics, pages 111-113, which is a part of MTUS, and [www.drugs.com](http://www.drugs.com) Dendracin Lotion, Side Effects, Warnings , which is not a part of MTUS.

Rationale for the Decision:

Clinical literature indicates that Dendracin lotion is a topical compounded lotion containing methyl salicylate 30%, Capsaicin 0.025%, and menthol 10%. The Chronic Pain Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine their efficacy and safety and they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The Chronic Pain guidelines also indicate that topical salicylates are recommended as being more effective than placebo. While the guidelines do not specifically address menthol, Capsaicin is indicated by the guidelines as recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations of Capsaicin at 0.025% are primarily for the treatment of osteoarthritis. A formulation of 0.075% has been primarily studied for postherpetic neuralgia, diabetic neuropathy, and post mastectomy pain. The documentation submitted for review fails to indicate that the employee is currently diagnosed with arthritis for which the current formulation of Capsaicin is indicated at 0.025%. Furthermore, there is a lack of documentation indicating the specific benefit from the use of Dendracin lotion. **The request for unknown prescription of Dendracin Lotion is not medically necessary and appropriate.**

**6) Regarding the request for unknown prescription of Ibuprofen:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Anti-inflammatory medications, page 22, which is a part of MTUS.

Rationale for the Decision:

The Chronic Pain guidelines indicate that anti-inflammatories are the traditional first line of treatment to reduce pain so that activity and functional restoration can resume, but long-term use may not be warranted. The documentation submitted for review indicates that the employee has been prescribed ibuprofen since at least 04/24/2013. Furthermore, notes indicate that the employee has had minor increase in range of motion with improvement of flexion of 45 degrees, right lateral bending and left lateral bending of 20 degrees, since initiation of ibuprofen. Furthermore, there is a noted 1 point decrease in the employee's pain scales since the prescription of ibuprofen. While the documentation submitted for review supports the recommendation for ibuprofen, the submitted request fails to detail the dose or quantity of the medication requested. **The request for unknown prescription of Ibuprofen 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

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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.