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Independent Medical Review
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MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/24/2013

Employee:	[redacted]
Claim Number:	[redacted]
Date of UR Decision:	7/12/2013
Date of Injury:	9/12/1996
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005734

DEAR [redacted],

MAXIMUS Federal Services has completed the Independent Medical Review ("IMR") of the above workers' compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [redacted]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in Texas. 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

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 [redacted]
- Medical Treatment Utilization Schedule (MTUS)

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 52-year-old male who reported an injury on 09/21/1996. The mechanism of injury was not provided for review. The patient underwent lumbar spinal fusion at the L5-S1 level in 2005. The patient had continued back pain. The patient's medications included morphine sulfate, ibuprofen, Kadian, and clonazepam. The patient underwent an MRI and was diagnosed with a T10 compression fracture. Physical findings included decreased range of motion secondary to pain rated at 6/10. The patient's diagnoses included failed back fusion, a compression fracture, left foot drop. The patient's treatment plan included continued medications, possible surgical intervention.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. MSIR 30mg #360 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, on-going Mangement, pg. 78, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MSIR 30 mg #360 is not medically necessary or appropriate. The patient has continued pain complaints rated at 6/10. California Medical Treatment and Utilization Schedule recommends continued use of opioids for chronic pain management when they are supported by an assessment of pain relief as related to the medication, increased functional capabilities, an assessment of side effects, and evidence of compliance with a prescribed medication schedule. The clinical

documentation submitted for review does indicate that the patient's pain levels are stable on the current medication schedule, there are no side effects, or evidence of aberrant behavior. However, the clinical documentation does not include any evidence of increased functional benefit as it results from the medication schedule. Additionally, California Medical Treatment Guidelines do not recommend opioid usage beyond the morphine daily equivalent of 120 mg. The clinical documentation submitted for review does not provide evidence of the frequency that the patient is prescribed this medication. Therefore, it cannot be determined if the prescription exceeds the morphine daily equivalent.

2. Motrin 800mg #90 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidenced based guidelines for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, pg. 70-73, which is part of MTUS.

The Physician Reviewer's decision rationale:

The Motrin 800 mg #90 is not medically necessary or appropriate. The clinical documentation does indicate that the patient has 6/10 pain. California Medical Treatment and Utilization Schedule recommends higher doses of ibuprofen for arthritis. Doses greater than 400 mg are not recommended, as there is no evidence to support that greater relief of pain is obtained for mild to moderate pain. The requested dosage exceeds this guideline recommendation. The clinical documentation does not provide any functional benefit as a result of the requested medication. As such, continued use would not be supported.

3. Klonopin 1mg #120 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, page 24, which is part of MTUS.

The Physician Reviewer's decision rationale:

The requested Klonopin 1 mg #120 is not medically necessary or appropriate. The patient does have continued pain complaints. It is noted within the documentation that the patient has reduced the amount of Klonopin that he is taking; however, California Medical Treatment and Utilization Schedule does not recommend benzodiazepines in the long-term use for chronic pain. Therefore, this medication would not be indicated, as the documentation provides evidence that the patient has been on this medication for an extended duration of time. Additionally, the documentation does not include any significant functional benefit as a result of this medication.

4. Lioderm patches is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidlines, Topical Analgesics, page 111, which is part of MTUS.

The Physician Reviewer's decision rationale:

The Lidoderm patches are not medically necessary or appropriate. The patient does have continued back pain. California Medical Treatment and Utilization Schedule does recommend the use of lidocaine transdermal patches when there is evidence of a trial of first line therapy that has failed to treat the patient's neuropathic pain. The clinical documentation submitted for review does not provide evidence that the patient has failed to respond to first line antidepressants or antiepilepsy drugs. Additionally, there is no documentation to support that the patient's pain is neuropathic in nature. As such, the requested Lidoderm patches are not medically necessary or appropriate.

5. Flexeril 10mg #90 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidenced based guidelines for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine (Flexeril), pg. 41, which is part of MTUS.

The Physician Reviewer's decision rationale:

The requested prescription of Flexeril 10 mg #90 between 06/25/2013 and 06/07/2013 is not medically necessary or appropriate. The patient does have continued pain complaints rated at a 6/10. California Medical Treatment Utilization Schedule recommends Flexeril or cyclobenzaprine as an option for a short course of therapy. California Medical Treatment Utilization Schedule states, "the effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better." Treatment should be brief. As the request is for 90 pills, duration of treatment exceeds guideline recommendations. The clinical documentation submitted for review does not provide any exceptional factors to support exceeding guideline recommendations.

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.

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