
Notice of Independent Medical Review Determination

Dated: 12/6/2013

[REDACTED]

[REDACTED]

Employee:

[REDACTED]

[REDACTED]

Date of UR Decision:

7/8/2013

Date of Injury:

11/1/2000

IMR Application Received:

8/1/2013

MAXIMUS Case Number:

CM13-0005829

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Flexeril 10mg #90 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 urine drug screen is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **one (1) Toradol 60mg intramuscular (IM) injection is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Opana ER 20mg #60 is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Opana IR 10mg #120 is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Kava Kava #90 is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Trazodone 50mg #60 is medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for **Sinralyne PM #60 is not medically necessary and appropriate.**

- 9) MAXIMUS Federal Services, Inc. has determined the request for **1 Vitamin B-12 intramuscular (IM) injection is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for **Flector patch 1.3% #60 is not medically necessary and appropriate.**
- 11) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20mg #30 is not medically necessary and appropriate.**
- 12) MAXIMUS Federal Services, Inc. has determined the request for **Medrox patch #120 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/22/2013. 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 **Flexeril 10mg #90 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 urine drug screen is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **one (1) Toradol 60mg intramuscular (IM) injection is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Opana ER 20mg #60 is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Opana IR 10mg #120 is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Kava Kava #90 is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Trazodone 50mg #60 is medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for **Sintralyn PM #60 is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for **1 Vitamin B-12 intramuscular (IM) injection is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for **Flector patch 1.3% #60 is not medically necessary and appropriate.**
- 11) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20mg #30 is not medically necessary and appropriate.**
- 12) MAXIMUS Federal Services, Inc. has determined the request for **Medrox patch #120 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 Anesthesiology and Pain Management, has a subspecialty in Acupuncture 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:

UR performed 7/8/13 for diagnosis of severe hip pain as well as muscle pains and recent finding of metastatic lesion in the hip. Most recent provider note reviewed by UR was 6/17/13. The clinical issues at hand are whether the 1 prescription of Flexeril 10mg #90 is/are medically necessary and appropriate, whether the 1 urine drug screen is/are medically necessary and appropriate, whether the 1 Toradol 60mg IM injection is/are medically necessary and appropriate, whether the 1 prescription of Opana ER 20mg #60 is/are medically necessary and appropriate, whether the 1 prescription of Opana IR 10mg #120 is/are medically necessary and appropriate, whether the 1 prescription of Kava Kava #90 is/are medically necessary and appropriate, whether the 1 prescription of Trazodone 50mg #60 is/are medically necessary and appropriate, whether the 1 prescription of Sintralyne PM #60 is/are medically necessary and appropriate, whether the 1 Vitamin B-12 IM injection is/are medically necessary and appropriate, whether the 1 prescription of Flector patch 1.3% #60 is/are medically necessary and appropriate, whether the 1 prescription of Prilosec 20mg #30 is/are medically necessary and appropriate, whether the 1 prescription of Medrox patch #120 is/are medically necessary and appropriate.

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 Flexeril 10mg #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, Cyclobenzaprine (flexeril, Amrix, Fexmid, generic available), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for pain), pg. 63, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." Page 41 notes "Treatment with cyclobenzaprine should be brief". The employee is not being treated for an

acute exacerbation of chronic back pain, so the requested treatment is not medically necessary. **The request for Flexeril 10mg #90 is not medically necessary and appropriate.**

2) Regarding the request for 1 urine drug screen:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Drug Testing, Pg. 43, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines state “Recommended...to assess for presence or use of illegal drugs” in injured workers on chronic opiate therapy. The MTUS stipulates a number of requirements for opiate therapy for pain, including risk management via urine drug testing to rule out predictors for abuse. **The request for 1 urine drug screen is medically necessary and appropriate.**

3) Regarding the request for one (1) Toradol 60mg intramuscular (IM) injection:

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, Ketorolac (Toradol, generic available), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Ketorolac (Toradol, generic available), pg. 72, which is part of the MTUS.

Rationale for the Decision:

MTUS states NSAIDs for Osteoarthritis (including knee and hip): recommended at the lowest dose for the shortest period in patients with moderate to severe pain” and “NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain.” MTUS citation above indicates that ketorolac is not indicated for mild or chronic pain; the employee was administered this one time for acute, severe, nociceptive pain likely associated with painful malignancy. The employee was appropriately treated for severe acute pain with a ketorolac injection, so the requested treatment/service is medically necessary. **The request for one (1) Toradol 60mg intramuscular (IM) injection is medically necessary and appropriate.**

4) Regarding the request for Opana ER 20mg #60:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pg. 81, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate, "Nociceptive pain: Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." Since the employee has x-ray evidence of cancer in their painful area, the requested treatment/service is medically necessary. **The request for Opana ER 20mg #60 is medically necessary and appropriate.**

5) Regarding the request for Opana IR 10mg #120:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pg. 81, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate, "Nociceptive pain: Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." Since the employee has x-ray evidence of cancer in their painful area, the requested treatment/service is medically necessary. **The request for Opana IR 10mg #120 is medically necessary and appropriate.**

6) Regarding the request for Kava:

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 Official Disability Guidelines (ODG), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Cochrane Review, The Cochrane Library, Oxford, which is not part of the MTUS.

Rationale for the Decision:

Medical records submitted and reviewed indicate no documentation of history of anxiety disorder in the employee, so there is no medical necessity demonstrated for the employee. **The request for Kava is not medically necessary and appropriate.**

7) Regarding the request for Trazodone 50mg #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 Official Disability Guidelines (ODG), Mental Illness and Stress, which is not part of the 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), Mental Illness and Stress.

Rationale for the Decision:

Medical records submitted and reviewed indicate the employee carries the diagnosis of Chronic Pain related depression and insomnia. ODG citation above states "Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric conditions such as depression or anxiety". Therefore, the employee meets the definition of medical necessity. **The request for Trazodone 50mg #60 is medically necessary and appropriate.**

8) Regarding the request for Sintralyn PM #60:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter.

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 Medical Evidence:

<http://www.fda.gov/downloads/scienceresearch/specialtopics/womenshealthresearch/ucm247894.pdf>

Rationale for the Decision:

No guidance from MTUS, ODG, ACOEM, National Guideline Clearinghouse, nor FDA.gov indicating efficacy for any indication. With no affirmative evidence for efficacy, and no documentation demonstrating this medication's efficacy, it does not meet medical necessity. **The request for Sintralyn PM #60 is not medically necessary and appropriate.**

9) Regarding the request for 1 Vitamin B-12 intramuscular (IM) injection:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter.

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 Medical Evidence:

<http://www.fda.gov/food/ingredientspackaginglabeling/gras/scogs/ucm261331.htm>

Rationale for the Decision:

No guidance from MTUS, ODG, ACOEM, National Guideline Clearinghouse, nor FDA.gov for any indication other than B12 deficiency. No documentation that this patient has B12 deficiency. With no affirmative evidence for efficacy for any other indication other than B12 deficiency, and no documentation demonstrating this medication's efficacy, it does not meet medical necessity. **The request for 1 Vitamin B-12 intramuscular (IM) injection is not medically necessary and appropriate.**

10) Regarding the request for Flector patch 1.3% #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, NSAIDs, GI symptoms & cardiovascular risk, which is part of the MTUS, and the Official Disability Guidelines (ODG), Pain (Acute and Chronic), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg. 112, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines state, "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use FDA-approved agents: Voltaren® Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." The employee's provider has indicated the reason for diclofenac patches is that the employee cannot tolerate systemic NSAIDs due to gastroesophageal junction/hiatal hernia concerns. However documentation is lacking regarding the site of pain treated with the patches and this will be required to affirm medical necessity. **The request for Flector patch 1.3% #60 is not medically necessary and appropriate.**

11)Regarding the request for Prilosec 20mg #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, NSAIDs, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, pg. 68, which is part of the MTUS.

Rationale for the Decision:

Not taking oral NSAID; documentation needed to assert GI symptoms and response to therapy with this medication to support medical necessity. **The request for Prilosec 20mg #30 is not medically necessary and appropriate.**

12)Regarding the request for Medrox patch #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, Capsaicin, topical, which is part of the MTUS.

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

Rationale for the Decision:

The agents found in MEDROX are methyl salicylate, menthol, and capsaicin. Methyl salicylate may have an indication for chronic pain in this context. Per MTUS p105, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004)." Capsaicin may have an indication for chronic pain in this context. Per MTUS p 112 "Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis...". MTUS also states "Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1." However, the preponderance of evidence indicates that overall this medication is not medically necessary. There is no documentation of intolerance to oral pain medication and the employee needs an alternative treatment in the form of a topical analgesic. **The request for Medrox patch #120 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.