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**Notice of Independent Medical Review Determination**

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/23/2013

5/19/2011

8/2/2013

CM13-0006048

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Omeprazole DR 20mg #120 1 q12h prn is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Naproxen 550mg #120 1 q12h as needed is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Ondansetron ODT 8mg #30 x2 =60 no more than 2/day is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine HCL 7.5mg #120 1 98h prn not to exceed more than 3/day is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Sumatriptan Succinate 25mg #9 x2 1 =18 at onset of headache and repeated 2 hours later prn, no more than 4/day is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Medrox = 30 change patch 1 to 2 times daily is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol ER 150mg #90 once a day as needed is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/30/2013. 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 **Omeprazole DR 20mg #120 1 q12h prn is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Naproxen 550mg #120 1 q12h as needed is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Ondansetron ODT 8mg #30 x2 =60 no more than 2/day is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine HCL 7.5mg #120 1 98h prn not to exceed more than 3/day is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Sumatriptan Succinate 25mg #9 x2 1 =18 at onset of headache and repeated 2 hours later prn, no more than 4/day is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Medrox = 30 change patch 1 to 2 times daily is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol ER 150mg #90 once a day as needed is 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:

Patient with injury date of 5/19/11, diagnoses of lateral epicondylitis, CTS, cervicalgia, and cubital tunnel syndrome. EMG/NCV studies by Dr. [REDACTED] showed normal studies for right and mild CTS on left.

8/19/13, pain re-evaluation, Pending hand surgery, medications Tramadol and zanaflex, continue with PT. Zanaflex for sleep. Impact of function discussed and meets criteria for continuation of medication management. Opiates have allowed for increase in ADL's and function. No discussion regarding the efficacy of above listed meds.

7/22/13, Dr. [REDACTED] pain notes. Same template discussion regarding opiate renewal. Patient recently had lumbar ESI with positive response. Under medication, same template discussion. No specifics are provided about any of the meds. Pain level 5/10 with meds and 8/10 without meds.

7/15/13, treater's note. Patient has neck and low back pain. Pt.had right CTR, waiting for left CTR. Migrainous headaches. Pt has stomach upset with Naproxen.

#### **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 Provider
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for Omeprazole DR 20mg #120 1 q12h prn:**

##### 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 MTUS guidelines.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, page 69, which is part of the MTUS.

##### Rationale for the Decision:

The MTUS Chronic Pain guidelines indicate that with intermediate risk for gastrointestinal events, a non-selective NSAID with a proton pump inhibitor (PPI) such as omeprazole, may be indicated. The records submitted for review indicate that the employee has gastric side effects from the use of NSAIDs and use of omeprazole is support by MTUS. The request for Omeprazole DR 20mg #120 1 q12h prn is medically necessary and appropriate.

#### **2) Regarding the request for Naproxen 550mg #120 1 q12h as needed:**

##### 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 MTUS guidelines, NSAIDs.

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

Rationale for the Decision:

The MTUS Chronic Pain guidelines indicate that NSIDs are anti-inflammatory medications utilized for pain relief and to aid in activity and functional restoration resumption. The records submitted for review indicate that the employee has chronic low back pain and is prescribed this medication as supported by the MTUS guidelines. The request for Naproxen 550mg #120 1 q12h as needed is medically necessary and appropriate.

**3) Regarding the request for Ondansetron ODT 8mg #30 x2 =60 no more than 2/day:**

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 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), Antiemetics.

Rationale for the Decision:

The records submitted for review indicate that the employee suffers from nausea due to opiates. The Official Disability Guidelines (ODG), do not support the use of Zolfran (Ondansetron) for treatment of opiate induced nausea. The request for Ondansetron ODT 8mg #30 x2 q12h as needed is not medically necessary and appropriate.

**4) Regarding the request for Cyclobenzaprine HCL 7.5mg #120 1 98h prn not to exceed more than 3/day:**

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 MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, page 64, which is part of the MTUS

Rationale for the Decision:

The MTUS Chronic Pain guidelines do not support use of flexeril for chronic pain on a chronic basis. It is recommended for a short term use only. The review of the submitted records clearly indicates that this medication is being used by the employee on a daily basis and monthly. The request for Cyclobenzaprine HCL 7.5mg #120 1 98h prn not to exceed more than 3/day is not medically necessary and appropriate.

**5) Regarding the request for Sumatriptan Succinate 25mg #9 x2 1 =18 at onset of headache and repeated 2 hours later prn, no more than 4/day:**

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 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.

Rationale for the Decision:

The Official Disability Guidelines support the use of triptans for migraines and not migrainous cervicogenic pain. The records submitted for review revealed that the treating provider indicated that the employee has migrainous nature of headaches and therefore requires Sumatriptan. The records do not indicate that the employee has been diagnosed with migraine headaches, but does indicate that the headaches arise from periods of increased pain in the cervical spine, which is cervicogenic and therefore not supported by the guidelines. The request for Sumatriptan Succinate 25mg #9 x2 1=18 is not medically necessary and appropriate.

**6) Regarding the request for Medrox = 30 change patch 1 to 2 times daily :**

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 MTUS.

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

Rationale for the Decision:

The MTUS Chronic Pain guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The records submitted for review did not document that the employee had a trial antidepressants or anticonvulsants previously and therefore the requested topical analgesic patch is not indicated. The request for Medrox = 30 change patch 1 to 2 times daily is not medically necessary and appropriate.

**7) Regarding the request for Tramadol ER 150mg #90 once a day as needed:**

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 MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids for neuropathic pain, pages 82 and 93-94, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain guidelines indicate that Tramadol is recommended as a second line treatment for pain. The records submitted for review indicated that the employee has tried other opioids before Tramadol and therefore is supported by the guidelines in this case. The request for Tramadol ER 150mg #90 once a day as needed is 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.