

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

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Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/25/2013  
Date of Injury: 02/19/25005  
IMR Application Received: 8/5/2013  
MAXIMUS Case Number: CM13-0007239

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Oxycodone 15mg, every 8 hours, #90 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Oxycodone (Roxicodone) 15mg, #90 is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Duloxetine (Cymbalta) 60mg, daily, #30 with 1 refill is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Gabapentin (Neurontin) 600mg, every 8 hours, with 1 refill is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine (Flexeril) 10mg, #30 with 1 refill is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/4/2013. 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 **Oxycodone 15mg, every 8 hours, #90 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Oxycodone (Roxicodone) 15mg, #90 is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Duloxetine (Cymbalta) 60mg, daily, #30 with 1 refill is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Gabapentin (Neurontin) 600mg, every 8 hours, with 1 refill is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine (Flexeril) 10mg, #30 with 1 refill 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, has a subspecialty in Pain Medicine 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:

**Clinical Summary:** This 56-year-old male reported an injury on 2/19/05. The mechanism of injury

occurred when the patient slipped and fell, landing on his back and left arm. The diagnoses were cervical spondylosis without myelopathy and brachial neuritis or radiculitis. The case management notes dated 7/23/13 indicated that the patient reported a constant aching pain in the neck bilaterally, extending from the nuchal ridge down to the base of the neck. The patient reported bilateral trapezius burning pain, sharp bilateral infrascapular pain, and extreme pain in the bilateral forearms and into the thenar eminence and the entirety of both hands. The patient reported sharp, shooting pains starting in the neck and going down the arms into the fingers. The patient reported low back pain with some radiation into the lower extremities, and pain was more significant now that the neck pain had stabilized. The patient rated pain at a 6/10. The clinical nurse management notes indicated an exam showing that range of motion (ROM) of the neck was not tested. The left middle trapezius was noted to be tender to palpation. Spasm was not palpable in the superior trapezius, middle trapezius, or rhomboid muscles. ROM of the upper extremities was noted to be full, and the patient reported left shoulder pain with abduction past 90 degrees. The patient's gait was noted to be normal; heel and toe walk were able to be performed without difficulty, and the patient reported low back pain with palpation in the lumbosacral junction. Spasms and guarding were not noted bilaterally. ROM was noted to be within normal limits, and flexion was noted to be the fingers inches from the ground.

## 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 Oxycodone 15mg, every 8 hours, #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, page 78, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 78 and 80, which is part of the MTUS.

#### Rationale for the Decision:

The Chronic Pain Guidelines state, "Opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants)." The medical records provided for review show electrodiagnostic evidence of neuropathy. **The request for oxycodone 15mg, every eight (8) hours #90 is medically necessary and appropriate.**

**2) Regarding the request for Oxycodone (Roxicodone) 15mg, #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, page 78, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 78 and 80, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines state, "Opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants)." The medical records provided for review show electrodiagnostic evidence of neuropathy. **The request for oxycodone (Roxicodone) 15mg #90 is medically necessary and appropriate.**

**3) Regarding the request for Duloxetine (Cymbalta) 60mg, daily, #30 with 1 refill :**

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, page 15, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 15-16, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines recommend sixty (60) mg of duloxetine once a day as an off-label option for chronic pain syndromes. The medical records provided for review show electrodiagnostic evidence of neuropathy. **The request for duloxetine (Cymbalta) 60mg, daily #30 with one (1) refill is medically necessary and appropriate.**

**4) Regarding the request for Gabapentin (Neurontin) 600mg, every 8 hours, with 1 refill :**

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, page 16, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 16, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that gabapentin is "recommended for neuropathic pain (pain due to nerve damage)." The medical records provided for

review show electrodiagnostic evidence of neuropathy. **The request for gabapentin (Neurontin) 600mg, every eight (8) hours, with one (1) refill is medically necessary and appropriate.**

**5) Regarding the request for Cyclobenzaprine (Flexeril) 10mg, #30 with 1 refill**

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, page 41, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 41 and 63, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that cyclobenzaprine is recommended as an option, using a short course of therapy. The guidelines also recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The medical records provided for review do not indicate that the medication was prescribed for low back pain. **The request for cyclobenzaprine (Flexeril) 10mg #30 with one (1) refill 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.