MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 11/25/2013

[redacted]

[redacted]

Employee:	[redacted]
Claim Number:	
Date of UR Decision:	7/17/2013
Date of Injury:	9/4/2012
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007366

1) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Cyclobenzaprine 7.5mg is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Pantoprazole 20mg is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Naproxen 550mg is medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Terocin lotion 120g #2 bottles is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request for **1 bilateral L5 transforaminal epidural steriod injection 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 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/5/2013. 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 **1 prescription of Cyclobenzaprine 7.5mg is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Pantoprazole 20mg is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Naproxen 550mg is medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Terocin lotion 120g #2 bottles is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request for **1 bilateral L5 transforaminal epidural steriod injection 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:
45 y/o female injured worker has been diagnosed with Brachial Neuritis, lumbar and cervical degeneration, cervical hyperextension, hyperflexion, thoracic sprain/strain, sciatica, and cephalgia. UR was performed on 7/17/13. Dr [redacted] note regarding chiropractic care was available for review on 7/11/13.

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 1 prescription of Cyclobenzaprine 7.5mg:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the California Chronic Pain Medical Treatment Guidelines (May 2009), which is part of the MTUS.

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

Rationale for the Decision:
The UR analysis states "In regards to the request for cyclobrnzaprine, the current evidence based guidelines recommend its use for short term therapy. According to the evidence based guidelines, the effectiveness of Cyclobenzaprine on low back pain is modest and is greatest in the first 4 days of treatment. Overall, the guidelines do not recommend the use of this medication for greater than 2-3 weeks."

As per citation above, non-sedating muscle relaxants are to be used with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. **The request for 1 prescription of Cyclobenzaprine 7.5mg is not medically necessary and appropriate.**

2) **Regarding the request for 1 prescription of Pantoprazole 20mg:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the California Chronic Pain Medical Treatment Guidelines (May 2009), 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:
Per the UR, "The request for pantopazole was non certified because the medication was determined to be not medically necessary. The employee did not meet the criteria for proton pump inhibitors due to a lack of gastrointestinal risk factors and did not have a history of gastointedtinal complaints. In the appeal letter, dated 7/12/13, Dr[redacted] stated that the employee required prophylaxis pantoprozole because of obesity, diabetes, and the use of NSAIDs." **The request for 1 prescription of Pantoprazole 20mg is not medically necessary and appropriate.**

3) **Regarding the request for 1 prescription of Naproxen 550mg:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the California Chronic Pain Medical Treatment Guidelines (May 2009), which is part of the MTUS.

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

Rationale for the Decision:
Per UR determination, naproxen was approved, and is not at dispute. **The request for 1 prescription of Naproxen 550mg is medically necessary and appropriate.**

4) **Regarding the request for 1 prescription of Terocin lotion 120g #2 bottles:**

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 California Chronic Pain Medical Treatment Guidelines (May 2009), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topicals, pg. 111, which is part of the MTUS.

Rationale for the Decision:
Terocin contains menthol. The CA MTUS, ODG, National Guidelines Clearinghouse, and ACOEM provide no evidence-based recommendations regarding the topical application of menthol. Since menthol is not medically indicated, than the overall product is not indicated per MTUS as outlined below. Note the statement on page 111: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. **The request for 1 prescription of Terocin lotion 120g #2 bottles is not medically necessary and appropriate.**

5) **Regarding the request for 1 bilateral L5 transforaminal epidural steriod 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 California Chronic Pain Medical Treatment Guidelines (May 2009), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Table 12-8, pg. 309, Low Back Pain, which is part of the MTUS.

Rationale for the Decision:
Per citation above, epidural injections are indicated for radicular pain to avoid surgery. Without diagnosis of radicular pain, radiculitis, or radiculopathy, medical necessity is not affirmed. **The request for 1 bilateral L5 transforaminal epidural steroid injection 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

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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.