

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/22/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/30/2013
Date of Injury:	5/19/2001
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0009861

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #120 +3 refills is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Soma 350mg #90 +3 refills is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Elavil 50mg #30 + refills is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **UDS to be performed at next visit is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the retrospective request for **injection of Celestone & amp; Marcaine to the left shoulder is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 7/30/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/19/2013. 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 **Norco 10/325mg #120 +3 refills** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Soma 350mg #90 +3 refills** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Elavil 50mg #30 + refills** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **UDS to be performed at next visit** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the retrospective request for **injection of Celestone & amp; Marcaine to the left shoulder** 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 Orthopedic Surgery, 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:

The patient is a 53-year-old male who reported an injury on 05/19/2001. The patient was treated by Dr. [REDACTED] on 01/07/2013, 04/10/2013, and 07/17/2013. Current diagnoses include sprain and strain of the cervical spine, status post left shoulder arthroscopy with debridement of SLAP lesion, status post non-displaced distal fracture of the right elbow, status post anterior and posterior lumbar fusion L3 to S1, contusion on neuroma of the left knee, and status post arthroscopy, meniscectomy, and chondroplasty of the right knee. The patient presented with complaints of 8/10 left shoulder pain with intermittent to frequent flare ups. Physical examination revealed tenderness to palpation of the anterior capsule of the left shoulder, decreased range of motion, and painful range of motion. Treatment plan included continuation of current medications and an injection with 2 cc of Celestone and 4 cc of Marcaine. The patient was instructed on home exercises for the left shoulder.

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 Norco 10/325mg #120 +3 refills:

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

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 74-82, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate, Short acting opioids are often used for intermittent or breakthrough pain. A therapeutic trial of opioids should not be employed until the employee has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Weaning should occur under direct ongoing medical supervision as a slow taper. As per the clinical notes submitted, the employee continues to present with complaints of 8/10 pain despite the ongoing use of this medication. Examination findings continue to reveal decreased and painful range of motion with tenderness to palpation. Satisfactory response to treatment is not indicated by the employee's decrease in pain level, increase in functional level, or improved quality of life. The employee has also presented with complaints of increased neck and low back pain that is exacerbated by activities of daily living. **The request for Norco 10/325mg #120 + 3 refills is not medically necessary and appropriate.**

2) Regarding the request for Soma 350mg #90 +3 refills

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Muscle Relaxants (for pain), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 63-66 and 124, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that muscle relaxants are recommended as a second line option for short-term treatment of acute exacerbations in employees with chronic low back pain. In most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Soma is not recommended for longer than 2 to 3 weeks. At the highest levels, the employee is at risk of delirium, seizures, or even death with abrupt discontinuation. Tapering should be individualized for each employee. As per the clinical notes submitted, the latest physical examination does not show any evidence of significant muscle tension or palpable muscle spasms. The employee continues to present with complaints of lower back pain, right knee pain, neck pain, and 8/10 left shoulder pain with frequent flare-ups, despite the ongoing use of this medication. **The request for Soma 350mg #90 + 3 refills is not medically necessary and appropriate.**

3) Regarding the request for Elavil 50mg #30 + refills :

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Antidepressants for chronic pain, page 13, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antidepressants for chronic pain, pages 13-16, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines indicate that antidepressants are recommended as a first line option for neuropathic pain and as a possibility for nonneuropathic pain. For chronic low back pain, tricyclic antidepressants have demonstrated a small to moderate effect and the effect on function is unclear. Tricyclic antidepressants are recommended over selective serotonin reuptake inhibitors, unless adverse reactions are a problem. Indications in controlled trials have shown effectiveness in treating central post-stroke pain, postherpetic neuralgia, painful diabetic and non-diabetic polyneuropathy, and post mastectomy pain. Amitriptyline is indicated for neuropathic pain." As per the clinical notes submitted, there is no evidence of neuropathic pain upon physical examination. The employee's current diagnoses include cervical spine strain, status post left shoulder arthroscopy, status post non-displaced distal fracture of the right elbow, status post lumbar fusion, contusion of the left knee, and status post arthroscopy with meniscectomy and chondroplasty of the right knee. The employee continues to present with complaints of pain in the left shoulder, neck, low back, and right knee with radiation and numbness to bilateral lower extremities despite the ongoing use of this current medication. **The request for Elavil 50mg #30 + 3 refills is not medically necessary and appropriate.**

4) Regarding the request for UDS to be performed at next visit:

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 77, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 43 and 77-78, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines indicate that drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. Urine drug screens are utilized prior to initiation of a therapeutic trial of opioids as well as during the ongoing management phase for patients with issues of abuse, addiction, or poor pain control. There is no evidence of a risk assessment screening provided for this employee; therefore, there is no indication that this employee falls under a high risk category for addiction or aberrant behaviors that would require frequent monitoring. The employee's injury was 12 years ago to date, and there is no evidence of documented misuse or noncompliance with the employee's current medication regimen. Repeat screening is not medically indicated. **The request for urine drug screen (UDS) to be performed next visit is not medically necessary and appropriate.**

5) Regarding the retrospective request for injection of Celestone & amp; Marcaine to the left shoulder :

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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pg. 204, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), Initial care, which is part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM Practice Guidelines indicate that initial care for shoulder complaints includes instruction in home exercise, manipulation by a manual therapist, physical modalities, and at home applications of heat or cold packs. Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy to include exercises and NSAID medication for 2 to 3 weeks. The total number of injections should be limited to 3 per episode, allowing for assessment of benefit between injections. Corticosteroid injections are recommended for impingement syndrome." As per the clinical notes submitted, the most recent physical examination revealed painful and decreased range of motion with tenderness over the anterior capsule of the left shoulder. It is noted that the employee is status post left shoulder

arthroscopy with debridement on 08/13/2002. Documentation of previous conservative therapy prior to the administration of injection is not provided. There is also no evidence of impingement syndrome documented on physical examination, corroborated by imaging studies, or listed as a current diagnosis. **The retrospective request for injection of Celestone & Marcaine to the left shoulder 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.