

Independent Medical Review Final Determination Letter

2474

Dated: 12/30/2013

IMR Case Number:	CM13-0021846	Date of Injury:	02/11/2003
Claims Number:	[REDACTED]	UR Denial Date:	08/19/2013
Priority:	STANDARD	Application Received:	09/09/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]		
Treatment(s) in Dispute Listed on IMR Application:			
000037-2001, 54907-0592, 054907-0592, S5001, S5001			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 57-year-old female who was injured while moving boxes from one desk to another, causing injury to the low back. Notes indicate the date of injury was 02/11/2003. Per clinical notes dated 08/06/2013, the patient was diagnosed with a lumbar sprain/strain and notes that the patient experiences cramps to the bilateral feet and toes secondary to radiating bilateral lower extremity symptoms secondary to low back pain. Notes indicate the patient also has spasms in the low back with numbness and tingling in the hands, arms, and feet. Additionally, the patient indicates having sleep issues and depression. Clinical notes from 08/02/2013 indicate the patient was provided prescriptions for Soma and Norco 10/325 mg, as well as for Gabapentin 600 mg for neuropathic pain and trazodone 50 mg for insomnia and depression.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Soma 350mg qty 120 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Treatment Guidelines page 65, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Antispasmodics page 29 and page 65, which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS Chronic Pain Guidelines state that Soma (Carisoprodol) is not indicated for longer than a 2 to 3 week period. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. Tapering should be individualized for each patient. While the documentation submitted for review indicates the employee to have complaints of muscle spasms, the clinical notes submitted for review indicate the employee has been prescribed Soma since at least 04/03/2013. Given the guideline recommendation is only for short-term use for treatment of muscle spasms, the request for the medication is not supported. **The request for Soma 350mg qty 120 is not medically necessary and appropriate.**

2. Gabapentin 600mg qty 90 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Treatment Guidelines pages 18-19, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Anti-Epilepsy drugs, page 18 which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS Chronic Pain Guidelines state that Gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. However, while Gabapentin may be effective for the treatment of neuropathic pain, there is a lack of documentation submitted for review detailing objective clinical findings supporting recommendation for the use of this medication. The employee details subjective complaints of low back pain and radiating bilateral lower extremity symptoms with cramping of the feet and toes; however, there is no indication of the employee having had benefit from prior administration of Gabapentin. **The request for Gabapentin 600mg qty 90 is not medically necessary and appropriate.**

3. Dendracin Lotion 120ml is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Treatment Guidelines, pages 111-113 which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Topical Analgesics, pages 105, 111-113, which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS Chronic Pain Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; also, that they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control; however, there is little to no research to support the use of many of these agents. The Guidelines also state that salicylate topicals are recommended as significantly better than placebo in chronic pain. However, while topical salicylates, such as Dendracin lotion may be indicated for use, there is a lack of documentation submitted in the review supporting the use of topical menthol and benzocaine. Additionally, there is no indication in the notes of demonstrated efficacy in controlling the employee's pain. **The request for Dendracin Lotion 120ml is not medically necessary and appropriate.**

4. Retrospective Gabapentin 600mg #90 dispensed 8/2/13 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Treatment Guidelines pages 18-19, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Anti-Epilepsy drugs, page 18 which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS Chronic Pain Guidelines state that Gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. However, while Gabapentin may be effective for the treatment of neuropathic pain, the clinical notes from 08/02/2013 were insufficient to detail objective clinical findings supporting the recommendation for the use of this medication. The employee details subjective complaints of low back pain and radiating bilateral lower extremity symptoms with cramping of the feet and toes; however, there is no indication of the employee having had benefit from prior administration of Gabapentin. Additionally, no objective clinical findings were noted on 08/02/2013 to support the prescription or administration of

Gabapentin. **The request for retrospective Gabapentin 600mg #90 dispensed 8/2/13 is not medically necessary and appropriate.**

5. Retrospective Dendracin Lotion 120ml qty 1 dispensed 8/2/13 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Treatment Guidelines, pages 111-113 which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Topical Analgesics, pages 105, 111-113, which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS Chronic Pain Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; also, that they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control; however, there is little to no research to support the use of many of these agents. MTUS Chronic Pain Guidelines state that salicylate topicals are recommended as significantly better than placebos in treating chronic pain. However, while topical salicylates, such as Dendracin lotion may be indicated for use, there is a lack of documentation submitted in the review supporting the use of topical menthol and benzocaine. Additionally, the clinical notes from 08/02/2013 indicate the employee has been prescribed this medication; however, there is no indication in the notes of demonstrated prior efficacy in controlling the employee's pain. **The request for retrospective Dendracin lotion 120 mL quantity 1 dispensed 8/2/13 is not medically necessary and appropriate.**

/MCC

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.

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CM13-0021846