

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/2/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/7/2013
Date of Injury: 6/27/2012
IMR Application Received: 8/14/2013
MAXIMUS Case Number: CM13-0010818

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for Tramadol ER 150mg #60 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for Pantoprazole 20mg #90 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for Cyclobenzaprine 7.5mg #90 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/14/2013 disputing the Utilization Review Denial dated 8/7/2013. 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 retrospective request for Tramadol ER 150mg #60 is **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for Pantoprazole 20mg #90 is **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for Cyclobenzaprine 7.5mg #90 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 Occupational 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:

All medical, insurance, and administrative records provided were reviewed.

The applicant is a 56-year-old former maintenance mechanic who has filed a claim for chronic back, neck, and shoulder pain reportedly associated with an industrial injury of June 27, 2012.

Thus far, he has been treated with the following: Analgesic medications; adjuvant medications; transfer of care to and from various providers in various specialties; prior right shoulder arthroscopy; prior left shoulder arthroscopy; and extensive periods of time off of work, on total temporary disability.

In a utilization review report of August 7, 2013, the claims administrator denied a request for tramadol, on the grounds that the applicant was using another opioid, hydrocodone. Protonix was also non-certified. Finally, Flexeril was also non-certified. The utilization reviewer stated that the applicant has no history of GI side effects to rationalize the denial for omeprazole.

In a prior medical progress note of July 16, 2013, it is stated that ongoing usage of analgesic medications does decrease pain. It is stated that the applicant experiences a 4-point reduction in pain through ongoing usage of tramadol. It is stated that usage of tramadol has resulted in diminution of hydrocodone usage. It is further stated that the applicant had stomach upset without proton pump inhibitors. Currently, while using

proton pump inhibitors, the issues of dyspepsia have resolved. The applicant remains off work, on total temporary disability. Medications are refilled.

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 retrospective request for Tramadol ER 150mg #60:

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 CA MTUS, 2009, Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use, page 80, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, When to Continue Opioids, pg. 80, which is part of the MTUS.

Rationale for the Decision:

As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain affected through ongoing opioid usage. In this case, the attending provider has clearly established that the employee does report reduction in pain through ongoing usage of opioids, specifically Tramadol. The employee reportedly exhibits improved performance of activities of daily living through ongoing usage of opioids, and has failed to return to work. Thus, on balance, continuing opioids in this context is indicated. Therefore, the original utilization review decision is overturned. The request is certified, on independent medical review. **The retrospective request for Tramadol ER 150mg #60 is medically necessary and appropriate.**

2) Regarding the retrospective request for Pantoprazole 20mg #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 CA MTUS, 2009 Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms and cardiovascular risk, page 68, which is part of the MTUS.

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

Rationale for the Decision:

As noted on page 69 of the MTUS Chronic Pain Medical Treatment Guidelines, usage of proton pump inhibitors such as pantoprazole is indicated in the treatment of NSAID-induced dyspepsia. In this case, the attending provider has further stated that the employee's previously described dyspepsia has ceased following her reduction of pantoprazole. Continuing Protonix in this context is indicated. Accordingly, the original utilization review decision is overturned. The request is certified, on independent medical review. **The retrospective request for Pantoprazole 20mg #90 is medically necessary and appropriate.**

3) Regarding the retrospective request for Cyclobenzaprine 7.5mg #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 CA MTUS, 2009, Chronic Pain Medical Treatment Guidelines, Muscle Relaxants (for pain), page 63, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine (flexeril), pg. 41, which is part of the MTUS.

Rationale for the Decision:

As noted on page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, addition of cyclobenzaprine to other agents is not recommended. In this case, the employee is using numerous other analgesic and adjuvant medications. Adding cyclobenzaprine to the mix is not endorsed, particularly on a long-term, sustained, or protracted basis. While there might have been some support for a limited certification of a small amount of cyclobenzaprine, to be used in the event of acute flare-ups of pain, there is no support for the thrice daily dosing proposed by the attending provider. Therefore, the original utilization review decision is upheld. The request remains non-certified. **The retrospective request for Cyclobenzaprine 7.5mg #90 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

/cmol

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.