

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **12/17/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/3/2013
Date of Injury:	11/8/2002
IMR Application Received:	7/19/2013
MAXIMUS Case Number:	CM13-0002155

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Flexeril 10mg is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Tagamet 300mg is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **lumbar epidural steroid injection (ESI) is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **radiofrequency ablation sacroiliac is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Flexeril 10mg** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Tagamet 300mg** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **lumbar epidural steroid injection (ESI)** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **radiofrequency ablation sacroiliac** 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 Orthopaedic Surgeon, 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.

Clinical Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated 7/3/2013.

“This 52-year-old female had a date of injury of 11/8/02. The mechanism of injury was not documented in the medical records. The diagnoses included thoracic spondylosis without myelopathy, lumbosacral spondylosis without myelopathy, displacement of the intervertebral disc site unspecified without myelopathy, degeneration of the lumbar or lumbosacral intervertebral disc, thoracic or lumbosacral neuritis or radiculitis unspecified, sacroiliac sprain, sprain of the thoracic region, status post surgical arthrodesis, and encounter for removal of internal fixation device.”

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:



1) Regarding the request for Norco 10/325mg:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

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

Rationale for the Decision:

Chronic Pain Guidelines indicate that the four A's, analgesics, activities of daily living, adverse side effects, and aberrant drug-taking behavior, should be observed for claimants on this type of medication. The records indicate that as of 06/20/2013, the employee was taking Norco, but the pain level was not objectively identified. It was reported that the previous injection had reduced the pain by approximately 50%. However, without documentation of an objective pain scale, this reviewer cannot state that this level of pain medication is needed for analgesia. **The request for Norco 10/325mg is not medically necessary and appropriate.**

2) Regarding the request for Flexeril 10mg :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for pain), pgs. 63-64, which is part of the MTUS.

Rationale for the Decision:

Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP.

Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Medical records submitted and reviewed indicated on 06/20/2013, when the employee was seen in clinic that there was no palpable muscle spasms on exam. The employee had reported that the previous injection had provided approximately 50% relief of the pain. Lacking documentation of significant need for this medication including documentation that the employee has spasms, this request is not considered medically necessary and is non-certified. **The request for Flexeril 10mg is not medically necessary and appropriate.**

3) Regarding the request for Tagamet 300mg:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

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:

This medication is used for short-term treatment of active duodenal ulcers or for maintenance therapy for duodenal ulcer patients, or for short term treatment of active benign gastric ulcers or erosive gastroesophageal reflux disease (GERD). It is also used for prevention of upper gastrointestinal bleeding in critically ill patients. MTUS chronic pain guidelines indicates that a medication such as this may be considered reasonable if there is current NSAID use and if there is cardiovascular risk identified. Additionally, the records do not indicate this employee has significant gastrointestinal upset or previous history of GERD or is critically ill. As such, the medical necessity of this request has not been documented by the records. **The request for Tagamet 300mg is not medically necessary and appropriate.**

4) Regarding the request for lumbar epidural steroid injection (ESI):

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Criteria for the use of Epidural steroid injections, pg. 46, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic studies. Medical records provided for this review do not include electrodiagnostic studies or imaging studies to objectively document radiculopathy. Furthermore, the last clinical note was dated 06/20/2013, and there has been a request for further information regarding this employee, and this has not been provided by the provider. The previous determination dated 05/23/2013 indicates that there was documentation noting the employee was status post a lumbar spine fusion in 2005 with noted decreased range of motion and moderate tenderness and a positive straight leg raise. However, no evidence of a recent trial or failure of conservative treatment had been documented for review; and therefore, the clinical notes do not support the procedure at that time. This reviewer is in agreement with that, as there is lack of documentation of significant current conservative care, as well as lack of objective evidence of radiculopathy. Therefore, this request is non-certified. **The request for lumbar epidural steroid injection (ESI) is not medically necessary and appropriate.**

5) Regarding the request for radiofrequency ablation sacroiliac:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based it's decision on the Chronic Pain Medical Treatment Guidelines (2009), pg. 102, which is part of the MTUS, and the Official Disability Guidelines (ODG) (2009), Treatment Index, Hip & Pelvis – Sacroiliac joint radiofrequency neurotomy, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG).

Rationale for the Decision:

ODG, hip and pelvis chapter, online version, states that this procedure is not recommended as the innervation of the S1 joint remains unclear and there is controversy regarding which technique is most efficacious. Medical records submitted and reviewed indicate this employee still has radicular findings on exam. With lack of support from the guidelines, the medical necessity of this procedure has not been demonstrated by the records provided. The request is non-certified. **The request for radiofrequency ablation sacroiliac 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

/ldh

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.