

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/10/2013

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/9/2013
Date of Injury: 9/12/2003
IMR Application Received: 7/19/2013
MAXIMUS Case Number: CM13-0002192

- 1) MAXIMUS Federal Services, Inc. has determined the request for Tramadol #180 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Naproxen Sodium #180 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole #180 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Flexeril #180 **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 7/9/2013. 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 Tramadol #180 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Naproxen Sodium #180 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole #180 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Flexeril #180 **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 Preventative Medicine and 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.

Case Summary:

The Utilization Review did not contain a clinical summary.

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 for Independent Medical Review (received 07/19/2013)
- Utilization Review from [REDACTED] (dated 07/9/2013)
- Medical records from Claims Administrator [REDACTED] [REDACTED] (dated 07/30/2013)
- Medical Treatment Utilization Schedule(MTUS)

1) Regarding the request for Tramadol #180:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, pages 78 and 94, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 9/12/2003 and reports chronic low back pain. The employee has been treated with analgesic medications, adjuvant medications, and an unspecified amount of physical therapy. On 4/3/2013, the provider noted the employee's medications are helpful. A progress dated 5/24/2013 documents the presence of mild left-sided sciatica with diminished lumbar range of motion, a mildly antalgic gait, and a diagnosis of mild L5 radiculopathy. A request was submitted for Tramadol #180.

The MTUS Chronic Pain Medical Treatment Guidelines indicate that Tramadol is recommended for moderate-to-severe pain and the total daily dosage of Tramadol should not exceed 400 mg per day. The records submitted and reviewed do not document how much Tramadol the employee is taking on a daily basis. While there is some evidence of improvement with Tramadol, the guidelines recommend the lowest possible dosage of opioids should be employed to improve function and pain. In this case, the provider has not documented any rationale why 180 tablet supply of Tramadol is indicated for this employee. The request for Tramadol #180 **is not medically necessary and appropriate.**

2) Regarding the request for Naproxen Sodium #180:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, page 73, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 9/12/2003 and reports chronic low back pain. The employee has been treated with analgesic medications, adjuvant medications, and an unspecified amount of physical therapy. On 4/3/2013, the provider noted the employee's medications are helpful. A progress dated 5/24/2013 documents the presence of mild left-sided sciatica with diminished lumbar range of motion, a mildly antalgic gait, and a diagnosis of mild L5 radiculopathy. A request was submitted for Naproxen Sodium #180.

The MTUS Chronic Pain Medical Treatment Guidelines indicate that twice daily dosage of Naproxen (Naprosyn) is standard. Higher dosage of 1500 mg to 1650 mg can be endorsed for limited periods of time. The employee's records do not include documentation of the dose or frequency of usage of Naproxen. There is also a lack of evidence of functional improvement through prior usage of naproxen as defined by diminished work restrictions, improved performance of activities of daily living, and/or diminished reliance on medical treatment. There is some discussion of improvement noted on prior progress notes. However, this is inadequate to support certification for Naprosyn in the requested quantity. The request for Naproxen Sodium #180 **is not medically necessary and appropriate.**

3) Regarding the request for Omeprazole #180:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, page 69, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 9/12/2003 and reports chronic low back pain. The employee has been treated with analgesic medications, adjuvant medications, and an unspecified amount of physical therapy. On 4/3/2013, the provider noted the employee's medications are helpful. A progress dated 5/24/2013 documents the presence of mild left-sided sciatica with diminished lumbar range of motion, a mildly antalgic gait, and a diagnosis of mild L5 radiculopathy. A request was submitted for Omeprazole #180.

The MTUS Chronic Pain Medical Treatment Guidelines suggest that omeprazole, a proton-pump inhibitor, can be employed in the treatment of non-steroidal anti-inflammatory drug (NSAID) induced dyspepsia. However, the documentation submitted and reviewed fails to establish the presence of NSAID induced, or standalone dyspepsia. Guideline criteria are not met. The request for Omeprazole #180 **is not medically necessary and appropriate.**

4) Regarding the request for Flexeril #180:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, page 41, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 9/12/2003 and reports chronic low back pain. The employee has been treated with analgesic medications, adjuvant medications, and an unspecified amount of physical therapy. On 4/3/2013, the provider noted the employee's medications are helpful. A progress dated 5/24/2013 documents the presence of mild left-sided sciatica with diminished lumbar range of motion, a mildly antalgic gait, and a diagnosis of mild L5 radiculopathy. A request was submitted for Flexeril #180.

The MTUS Chronic Pain Medical Treatment Guidelines note that the addition of cyclobenzaprine or Flexeril to other agents is not recommended. In this case, the employee is reportedly using multiple other analgesic and adjuvant medications. Adding cyclobenzaprine or Flexeril to the regimen is not recommended. In this case, as with the other agents, there is incomplete evidence of functional improvement as prior records suggested that there was some evidence of analgesia, but there is no recent documentation of such improvement. This is insufficient to support a 180-tablet certification. The request for Flexeril #180 **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;

Richard C. Weiss, MD, MPH, MMM, PMP
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.