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## Notice of Independent Medical Review Determination

Dated: 11/1/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/3/2013

5/15/2001

7/22/2013

CM13-0002439

- 1) MAXIMUS Federal Services, Inc. has determined the request for Flexeril 10mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Vicodin ES #120 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Ketoprofen 75mg **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Prilosec/omeprazole 20mg **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Lyrica 50mg #60 **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 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 Flexeril 10mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Vicodin ES #120 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Ketoprofen 75mg **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Prilosec/omeprazole 20mg **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Lyrica 50mg #60 **is 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 Family Medicine 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:**

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

"The patient is a 50 year old male with a date of injury of 5/15/2001. Under consideration is a request for 1 prescription of Flexeril 10mg; 1 prescription of Thermacare patches #120; 1 prescription of Vicodin ES. In regard to the request for 1 prescription of Ketoprofen 75mg, the reviewer determined that additional information was reasonably necessary in order to render a decision."

## 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 07/22/2013)
- Utilization Review Determination from [REDACTED] (dated 07/03/2013)
- Employee Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

### 1) Regarding the request for Flexeril 10mg:

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

The Claims Administrator based its decision on the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12), pg. 162, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pg. 64, which is part of the MTUS.

#### Rationale for the Decision:

The employee sustained a work related injury on 5/15//2001, to the back. Medical records provided for review indicate S1 persistent radiculitis, and stomach pain with medications usage. Treatments have included medication management. The request is for Flexeril 10mg.

MTUS Chronic Pain guidelines note Flexeril is recommended for short term use, because it may be habit forming, and reaches maximum number needed to treat at 2 weeks. The medical records submitted and reviewed indicate prolonged use of Flexeril for over a year and the records do not evidence improved function or pain relief as a result of this medication. **The request for Flexeril 10mg is not medically necessary and appropriate**

### 2) Regarding the request for Vicodin ES #120:

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

The Claims Administrator did not provide an evidence-basis for its decision.

The Expert reviewer based his/her decision on the Chronic Pain Guidelines, Opioids, criteria for use, pg. 76-77, which is part of the MTUS.

#### Rationale for the Decision:

The employee sustained a work related injury on 5/15//2001, to the back. 6/6/13 medical records provided for review indicate S1 persistent radiculitis, and stomach pain with medications usage. Treatments have included medication management. The request is Vicodin ES #120.

The Chronic Pain Guidelines indicate opioids are known to cause addiction and tolerance. For continuous pain a long acting opioid should be prescribed. The medical records indicate Vicodin usage for over a year. The records indicate there is continued use in combination with other analgesics, decreasing the ability to determine its effectiveness. **The request for Vicodin ES #120 is not medically necessary and appropriate**

### 3) Regarding the request for Ketoprofen 75mg:

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

The Claims Administrator did not provide an evidence-basis for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Guidelines, NSAIDs, GI symptoms & cardiovascular risk, pg. 68, which is part of the MTUS.

#### Rationale for the Decision:

The employee sustained a work related injury on 5/15//2001, to the back. 6/6/13 medical records provided for review indicate S1 persistent radiculitis, and stomach pain with medications usage. Treatments have included medication management. The request is for Ketoprofen 75 mg

The Chronic Pain Guidelines indicate NSAIDs (Ketoprofen) are to be used for short-term relief of chronic pain. Long-term use of NSAIDs can lead to kidney and gastrointestinal side effects. The medical records reviewed indicate long-term usage of this medication for over a year. **The request for Ketoprofen 75mg is not medically necessary, and appropriate.**

### 4) Regarding the request for Prilosec/Omeprazole 20mg:

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

The Claims Administrator did not provide an evidence-basis for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Guidelines, NSAIDs, GI symptoms & cardiovascular risk, pg. 68, which is part of the MTUS.

#### Rationale for the Decision:

The employee sustained a work related injury on 5/15//2001, to the back. 6/6/13 medical records provided for review indicate S1 persistent radiculitis, and stomach pain with medications usage. Treatments have included medication management. The request is for Prilosec/Omeprazole 20mg.

The Chronic Pain Guidelines indicate Prilosec is to be used for treatment of high risk gastrointestinal (GI) side effects from non-steroidal anti-inflammatory analgesics (NSAID) such as bleeding ulcers, perforation, and anti-coagulant use. The medical records provided for review do not evidence severe GI disturbances, and Ketoprofen usage is no longer indicated, therefore the use of Prilosec for GI protection is not indicated. **The request is for Prilosec/Omeprazole 20mg is not medically necessary and appropriate.**

## 5) Regarding the request for Lyrica 50mg #60:

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

The Claims Administrator did not provide an evidence-basis for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Guidelines, Pregabalin (Lyrica®), pg. 99, which is part of the MTUS and Baron R, Freynhagen R, Tölle TR, Cloutier C, Leon T, Murphy TK, Phillips K; A0081007 Investigators. "The efficacy and safety of pregabalin in the treatment of neuropathic pain associated with chronic lumbosacral radiculopathy." Pain 2010 Sep;150(3):420-7. doi: 10.1016/j.pain.2010.04.013. Epub 2010 May 20 and Saldaña MT, Navarro A, Pérez C, Masramón X, Rejas J. "A cost-consequences analysis of the effect of pregabalin in the treatment of painful radiculopathy under medical practice conditions in primary care settings." Pain Pract. 2010 Jan-Feb;10(1):31-41. doi: 10.1111/j.1533-2500.2009.00312.x., which is not part of the MTUS.

### Rationale for the Decision:

The employee sustained a work related injury on 5/15//2001, to the back. 6/6/13 medical records provided for review indicate S1 persistent radiculitis, and stomach pain with medications usage. Treatments have included medication management. The request is for Lyrica 50mg #60.

The Chronic Pain Guidelines indicate Lyrica is approved for the treatment of diabetic neuropathy, post herpetic neuralgia and fibromyalgia. However, more recent evidenced-based research indicates Lyrica can be effective in reducing pain in chronic radiculitis, is cost effective, and can improve time to return to work. **The request for Lyrica 50mg #60 is 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, 18<sup>th</sup> 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.