
Notice of Independent Medical Review Determination

Dated: 10/3/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/17/2013
Date of Injury: 5/8/2012
IMR Application Received: 7/22/2013
MAXIMUS Case Number: CM13-0002465

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription of Voltaren 100mg #30 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription of Protonix 20mg #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription of Flexeril 7.5 mg #90 **is not 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 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 a prescription of Voltaren 100mg #30 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription of Protonix 20mg #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription of Flexeril 7.5 mg #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 Physical Medicine and Rehabilitation 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:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 17, 2013:

"SUMMARY OF RECORDS:

The claimant is a 61 year-old male with reported DOI 5/30/12 to the lumbar spine. AP documented LBP and intermittent radiculopathy. He is prescribing multiple medications."

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 7/22/2013)
- Utilization Review Determination from [REDACTED] (dated 7/17/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

1) Regarding the retrospective request for a prescription of Voltaren 100mg #30:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), which is part of the Medical Treatment Utilization Schedule (MTUS), but did not cite a specific section. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), page 22, which is part of the MTUS.

Rationale for the Decision:

The employee was injured on 5/30/12 and has experienced low back pain with tingling and numbness that involves the medial aspect of both feet and the plantar surface. The medical records provided for review indicate sharp pain to the mid-back with occasional stabbing pains. Clinical notes submitted for review indicate pain increases with pushing, pulling, sitting, standing, lifting and other activities. A retrospective request was submitted for a prescription of Voltaren 100mg.

The MTUS Chronic Pain Guidelines recommend non-steroidal anti-inflammatory drugs for chronic back pain. The medical records submitted for review document that the patient has chronic low back pain. The retrospective request for a prescription of Voltaren 100mg #30 **is medically necessary and appropriate.**

2) Regarding the retrospective request for a prescription of Protonix 20mg #60:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), no pg. cited, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, pg.69, which is part of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 5/30/12 and has experienced low back pain with tingling and numbness that involves the medial aspect of both feet and the plantar surface. The medical records provided for review indicate sharp pain to the mid-back with occasional stabbing pains. Clinical notes submitted for review indicate pain increases with pushing, pulling, sitting, standing, lifting and other activities. A retrospective request was submitted for a prescription of Protonix 20mg #60.

The MTUS Chronic Pain Guidelines recommend non-steroidal anti-inflammatory drugs for treatment of gastrointestinal symptoms. The medical records submitted for review provide no documentation that this patient is at low, medium or high risk of gastrointestinal events. The retrospective request for a prescription of Protonix 20mg #60 **is not medically necessary and appropriate.**

3) Regarding the retrospective request for a prescription of Flexeril 7.5 mg #90:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), no pg. cited, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, pg.64, which is part of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 5/30/12 and has experienced low back pain with tingling and numbness that involves the medial aspect of both feet and the plantar surface. The medical records provided for review indicate sharp pain to the mid-back with occasional stabbing pains. Clinical notes submitted for review indicate pain increases with pushing, pulling, sitting, standing, lifting and other activities. A retrospective request was submitted for a prescription of Flexeril 7.5mg #90.

The MTUS Chronic Pain Guidelines indicate Flexeril (cyclobenzaprine) is recommended for short-term use, for no more than 2-3 weeks. The medical records submitted for review do not provide documentation that Flexeril is to be used for short-term use only. Based on the medical records provided for review, it appears that the requested Flexeril is being used long-term. The request for retrospective prescription for Flexeril 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;

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

/th

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.