MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 10/25/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/10/2013
Date of Injury:	1/31/1994
IMR Application Received:	7/23/2013
MAXIMUS Case Number:	CM13-0002703

1) MAXIMUS Federal Services, Inc. has determined the request for Norco 10/325mg #120 **is medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for Soma 350mg #120 **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for omeprazole 20mg #60 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/23/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/26/2013. 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 #120 **is medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for Soma 350mg #120 **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for omeprazole 20mg #60 **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 & 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 10, 2013:

Clinical History:
According to the clinical documentation, the patient is a 53-year old individual who sustained injuries to the bilateral knees and right upper extremity on 1/31/94. Mechanism of injury was not documented in the clinical records submitted with this request. According to the medical report dated 5/08/13 by Dr. [redacted] the patient presented with complaints of pain in the neck, upper back and both shoulders with radiation to both arms, both elbows, and both wrists. The patient also complained of pain in the mid back, lower back and both knees with radiation to both legs. Pain was associated with tingling in the arms, hands, legs and feet, numbness in the arms, hands and feet, and weakness in the arms and legs. Pain was constant in frequency and severe in intensity. Pain rated at 7 to 8/10 described as sharp, cutting, throbbing, dull, aching, pressure like, cramping, shooting, electric like and burning with muscle pain, pins and needles sensation and sweating. The patient stated that condition was chronic and TENS unit helped but already worn out. Patient also reported constipation and very frequent urination. Physical examination on right shoulder showed range of motion (ROM) as follows: forward flexion 90 degrees; abduction 100 degrees; external rotation 50 degrees; internal rotation 30 degrees; and extension 20 degrees. ROM on left shoulder: forward flexion 80 degrees; abduction 90 degrees; external rotation 35 degrees; internal rotation 45 degrees; and extension 15 degrees. Hawkin's test and drop test were positive bilaterally. Lumbar spine ROM as follows: forward flexion 50 degrees; extension 10 degrees; side bending on both right and left 20 degrees. Rotation was limited. There was mild loss of lumbar lordosis. Tenderness to palpation over the bilateral lumbar paraspinal muscles noted. Positive lumbar facet loading mancuver bilaterally and positive straight leg raise test on the right in the seated and supine position to 50 degrees. There was sacroiliac joint tenderness on the right and positive Patrick's test and positive Gaenslen's maneuver. Examination of bilateral knees revealed ROM decreased by 30%. Edema and crepitus noted. Tenderness to palpation over the medial joint line bilaterally. There was positive varus/valgus instability. Motor strength on right knee extension was 4+/5 and bilateral hip flexion was 4/5. Diminished sensation in bilateral L5 and S1 dermatomes of the lower extremities noted. Reflexes were symmetric at 1+/4 in bilateral

upper extremities and 1+/4 in bilateral lower extremities. The 12-panel urine toxicity screen showed positive results for Oxycodone and Opioids. Medications included Oxycontin 40 mg qid; Norco 10/325mg qid; Soma 350mg qid; Omeprazole 20 mg qd; Promolaxin 100 mg bid. The patient was diagnosed with lumbago (724.2); disorders of bursae and tendons I shoulder region (726.10); and osteoarthrosis localized, secondary involving lower leg (715.26) This is a review for medical necessity of the requested TENS Unit; Oxycontin 40mg; Norco 10/325mg; Soma 350mg; Omeprazole 20mg; and Promolaxin 100mg.

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 (dated 7/23/13)
- Utilization Review Determination from Claims Administrator (dated 7/10/13)
- Medical Treatment Utilization Schedule (MTUS)
- Employee medical records from Claims Administrator

1) **Regarding the request for Norco 10/325mg #120:**

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), (section not cited), pg. 91 which is a part of Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Long-term Opioid use, page 88-89, part of the MTUS.

Rationale for the Decision:
The employee sustained a work-related injury on 1/31/94 to the bilateral knees and right upper extremity. The medical records provided indicate treatments have included physical therapy, and medication management. The request is for Norco 10/325mg #120.

The MTUS Chronic Pain Treatment guidelines state that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. In this case, the clinical notes indicate that prescribed medications are effective in decreasing the level of pain experienced by the employee. The request for Norco 10/325mg #120 **is medically necessary and appropriate.**

2) **Regarding the request for Soma 350mg #120:**

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), (section not cited), pg.65 which is a part of Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Carisoprodol (Soma®, Soprodal 350™, Vanadom®, generic available), pg.65 relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:
The employee sustained a work-related injury on 1/31/94 to the bilateral knees and right upper extremity. The medical records provided indicate treatments have included physical therapy, and medication management. The request is for Soma 350mg #120.

The MTUS Chronic Pain Treatment guidelines do not recommend Soma for longer than a 2 to 3 week period. According to the medical records provided for review, the employee has been on this medication for longer than the recommended 2-3 week period. Therefore, the request for Soma 350mg #120 **is not medically necessary and appropriate.**

3) **Regarding the request for omeprazole 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 (2009), (section not cited), pg. 68-69, which is a part of Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, pg. 69, part of the MTUS.

Rationale for the Decision:
The employee sustained a work-related injury on 1/31/94 to the bilateral knees and right upper extremity. The medical records provided indicate treatments have included physical therapy, and medication management. The request is for omeprazole 20mg #60.

The MTUS Chronic Pain guidelines recommend omeprazole for individuals who are at risk for gastrointestinal (GI) events. The medical records provided for the employee do not indicate the employee has any GI complaints or risk factors. The request for omeprazole 20mg #60 **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

/hs

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.