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**Notice of Independent Medical Review Determination**

Dated: 10/7/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/16/2013  
Date of Injury: 6/23/2010  
IMR Application Received: 7/24/2013  
MAXIMUS Case Number: CM13-0003140

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription for Vicodin ES #75 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription for Flector Patches #30 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription for Neurontin 400mg #30 **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 for Vicodin ES #75 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription for Flector Patches #30 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for a prescription for Neurontin 400mg #30 **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 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 16, 2013

"According to the records made available for review, this is a 33-year-old female patient s/p injury 6/23/10. The patient most recently (7/1/13) presented with sharp dull pain that is progressing and constant. Physical examination revealed tenderness to palpation. Current diagnoses not specified. Treatment to date includes medication. Treatment requested here is retro meds: Vicodin ES #75, Flector patch #30 and Neurontin 400 mg #30."

### **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 7/24/2013)
- Utilization Review Determination from [REDACTED] (dated 7/16/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

**1) Regarding the retrospective request for a prescription for Vicodin ES #75: 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), pg. 79-81 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 based his/her decision on Chronic Pain Medical Treatment Guidelines (May, 2009) pg. 8, 11, 88-89, which are part of the MTUS and relevant and appropriate for the employee's clinical circumstance.

**Rationale for the Decision:**

The employee sustained a work-related injury on June 23, 2010 resulting in chronic back pain. Treatments have included medications and physical therapy. The request is for Vidodin ES # 75.

The MTUS Chronic Pain guidelines state that treatment shall be provided as long as the pain persists beyond the anticipated time of healing and throughout the duration of the chronic pain condition. According to the medical records provided for review the employee has been on opioids since at least 8/20/12 and the employee continues with chronic pain; there will be a transfer of care to pain management to further address pain issues. The request for Vidodin ES # 75 is medically necessary and appropriate.

**2) Regarding the retrospective request for a prescription for Flector Patches #30: Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:**

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) which is a medical treatment guideline not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated MTUS did not address the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

**Rationale for the Decision:**

The employee sustained a work-related injury on June 23, 2010 resulting in chronic back pain. Treatments have included medications and physical therapy. The request is for Flector patches #30.

The Official Disability Guidelines state that Flector patches are "Not recommended as a first-line treatment". The medical records reviewed show the employee was first using Tylenol, then Voltaren was added, and then the employee was switched to topical NSAIDs after gallbladder and weight loss surgery in 2011. Flurbiprofen and ketoprofen cream have also been tried. The records also indicate a diagnosis of lumbar sprain which meets guideline criteria for Flector patch. The request for Flector patches #30 is medically necessary and appropriate.

**3) Regarding the retrospective request for a prescription for Neurontin 400mg #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), pg. 18-19 which are 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.

Rationale for the Decision:

The employee sustained a work-related injury on June 23, 2010 resulting in chronic back pain. Treatments have included medications and physical therapy. The request is for Neurontin 400 mg #30.

MTUS Chronic Pain Medical guidelines state that Gabapentin (Neurontin's generic) is a first-line treatment for neuropathic pain. According to medical records provided for review, the employee has numbness and tingling down the right leg. While there is no documented evidence of radiculopathy, neuropathic pain has not been ruled out. The quality of the pain "numbness and tingling" down the right lower extremity is more indicative of neuropathic pain than nociceptive pain which would meet guideline criteria for gabapentin. The request for Neurontin 400 mg #30 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;

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