
Notice of Independent Medical Review Determination

Dated: 11/5/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	6/28/2013
Date of Injury:	1/4/2010
IMR Application Received:	7/23/2013
MAXIMUS Case Number:	CM13-0003163

- 1) MAXIMUS Federal Services, Inc. has determined the request for Fentanyl Patches 75mcg # 15 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Motrin 800mg # 60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Xanax 1mg # 30 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Soma 350mg # 90 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 6/28/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 Fentanyl Patches 75mcg # 15 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Motrin 800mg # 60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Xanax 1mg # 30 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Soma 350mg # 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 Internal 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 2, 2013:

“This 48-year-old male was Injured on 1/4/10. The mechanism of injury was a man hole ring and cover fell on the patient. The diagnoses were chronic lumbar backache, bilateral lower extremity radiculopathy pain, bilateral knee region arthralgia, chronic cervicalgia, bilateral upper extremity and bilateral shoulder region neuropathic pain, and recurrent myofascial strain. Above were the accepted body parts. The lungs, trunk, upper extremities, wrist, and psychiatric Issues were not accepted body parts, as per the utilization management. The patient also had severe recurrent cervicogenic headaches, which were significantly relieved by Imitrex, a triptan medication. that was effective for the treatment of migraine. A clinical evaluation on 6/4/13, documented that the pain scale was currently 8/10, in spite of an extensive list of medications including opioids. He noted cervical, lumbar, right wrist, bilateral leg, and bilateral knee pain, as well as, numbness in his thoracic spine. He had been taking medications and tolerated them well. No diagnostic studies were necessary at present. As per the provider, on examination, there was painful restricted cervical range of movements with diminished C6-C7 sensation in both upper extremities and also in the right C8 dermatome distribution the right upper extremity. The lumbar back had bilateral A to 51 dermatome sensory deficits, actually indicating global sensory deficit in both lower extremities.

There was painful restricted lumbar range of motion. The provider documented that the lumbar magnet!~ resonance imaging (MRI) showed LS-51 with a 7 mm left-sided disk herniation; severe left neuroforaminal stenosis and compression of the existing LS nerve root; and multilevel L4 to S1 degenerative disk disease. The results of the cervical MRI, if performed, were not available for review. The provider was seeking psychiatric referral because of reactive anxiety and depression, and indicated that the patient had multiple surgeries in the past. This may have indicated that the patient also had a failed lumbar surgery syndrome. This review was pertinent to the medical necessity of opioids, Percocet, Fentanyl patches, Carisoprodol, Motrin, Imitrex, and Xanax.”

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 7/25/2013
- Utilization Review Determination from Claims Administrator
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Fentanyl Patches 75mcg # 15:

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, Fentanyl, page 47, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Fentanyl, page 47, which is part of the MTUS.

Rationale for the Decision:

The employee was injured in an industrial accident on 1/04/2010. The records submitted indicate diagnoses include chronic lumbar backache, bilateral upper extremity radiculopathy pain, bilateral knee region arthralgia, chronic cervicalgia, bilateral upper extremity and bilateral shoulder region neuropathic pain, recurrent myofascial strain, and severe recurrent cervicogenic headaches. The submitted and reviewed records indicate that the most recent clinical evaluation, dated 6/04/13, indicated that the employee described the pain level at 8/10, despite taking extensive medications. A request was submitted for Fentanyl patches 75mcg # 15, Motrin 800mg # 60, Xanax 1mg # 30, and Soma 350mg # 90.

The MTUS Chronic Pain Guidelines indicate that Duragesic (Fentanyl patches) is used for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. The medical records do not document opioid tolerance or lack of control of pain by other methods (long-acting oral opioids). On this basis, the use of fentanyl patches would not be medically necessary. **The request for Fentanyl patches is not medically necessary and appropriate.**

2) Regarding the request for Motrin 800mg # 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, NSAIDs, page 67-68, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, page 67-68, which is part of the MTUS.

Rationale for the Decision:

The employee was injured in an industrial accident on 1/04/2010. The records submitted indicate diagnoses include chronic lumbar backache, bilateral upper extremity radiculopathy pain, bilateral knee region arthralgia, chronic cervicalgia, bilateral upper extremity and bilateral shoulder region neuropathic pain, recurrent myofascial strain, and severe recurrent cervicogenic headaches. The submitted and reviewed records indicate that the most recent clinical evaluation, dated 6/04/13, indicated that the employee described the pain level at 8/10, despite taking extensive medications. A request was submitted for Fentanyl patches 75mcg # 15, Motrin 800mg # 60, Xanax 1mg # 30, and Soma 350mg # 90.

The MTUS Chronic pain Guidelines indicate that ibuprofen is recommended as an option for short-term symptomatic relief. Given the concerns about side effects and the lack of efficacy documented in the medical records reviewed, the use of ibuprofen would not be medically necessary. **The request for Motrin 800mg # 60 is not medically necessary and appropriate**

3) Regarding the request for Xanax 1mg # 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, Benzodiazepines, page 24, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, page 24, which is part of the MTUS

Rationale for the Decision:

The employee was injured in an industrial accident on 1/04/2010. The records submitted indicate diagnoses include chronic lumbar backache, bilateral upper extremity radiculopathy pain, bilateral knee region arthralgia, chronic cervicalgia, bilateral upper extremity and bilateral shoulder region neuropathic pain, recurrent myofascial strain, and severe recurrent cervicogenic headaches. The submitted and reviewed records indicate that the most recent clinical evaluation, dated 6/04/13, indicated that the employee described the pain level at 8/10, despite taking extensive medications. A request was submitted for Fentanyl patches 75mcg # 15, Motrin 800mg # 60, Xanax 1mg # 30, and Soma 350mg # 90.

The MTUS Chronic Pain Guidelines indicate that alprazolam (Xanax) is not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. The

medical records do not document a clinical need or clinical indication for the use of alprazolam in this case. The records do not provide evidence that alprazolam has had a beneficial effect on the employee's pain or being is used for an accepted industrial injury. **The request for Xanax 1mg # 30 is not medically necessary and appropriate.**

4) Regarding the request for Soma 350mg # 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, Carisoprodol (SOMA), page 29, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Carisoprodol (SOMA), page 29, which is part of the MTUS.

Rationale for the Decision:

The employee was injured in an industrial accident on 1/04/2010. The records submitted indicate diagnoses include chronic lumbar backache, bilateral upper extremity radiculopathy pain, bilateral knee region arthralgia, chronic cervicgia, bilateral upper extremity and bilateral shoulder region neuropathic pain, recurrent myofascial strain, and severe recurrent cervicogenic headaches. The submitted and reviewed records indicate that the most recent clinical evaluation, dated 6/04/13, indicated that the employee described the pain level at 8/10, despite taking extensive medications. A request was submitted for Fentanyl patches 75mcg # 15, Motrin 800mg # 60, Xanax 1mg # 30, and Soma 350mg # 90.

The MTUS Chronic Pain Guidelines indicate that Soma is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. This medication is not indicated for long-term use. The medical records lack an appropriate indication for this medication. This medication has a potential for drug interaction/addiction and is not recommended for long-term use by MTUS. **The request for Soma 350mg # 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;

Paul Manchester, MD, MPH
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.