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

Notice of Independent Medical Review Determination

Dated: 11/20/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/11/2013
Date of Injury:	4/24/2012
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003211

1) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine Hydrochloride 7.5mg #120 is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Omeprazole DR 20mg #120 is medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **Ondansetron 8mg #60 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 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 **Cyclobenzaprine Hydrochloride 7.5mg #120 is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Omeprazole DR 20mg #120 is medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **Ondansetron 8mg #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 Preventive Medicine and Occupational Medicine, 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.

Expert Reviewer Case Summary:
The applicant, Ms. [redacted], is a represented 64-year-old [redacted] employee who has filed a claim for chronic low back pain reportedly associated with cumulative trauma at work first claimed on April 24, 2012.

Thus far, she has been treated with the following: Analgesic medications; adjuvant mediations; transfer of care to and from various providers in various specialties; and reported return to regular duty work.

A prior note of March 4, 2013, suggested that the applicant has, in fact, returned to regular work. The most recent progress note of June 3, 2013 is notable for comments that the applicant reports persistent mid back, low back, and bilateral hip pain. She is using Naprosyn but reports dyspepsia with the same. She states that the Naprosyn nevertheless is generating improved performance of activities of daily living. The applicant exhibits 3 to 3+/5 lower extremity strength with severely guarded and restricted range of motion noted. Recommendations are made for the applicant to pursue multilevel lumbar spine surgery while employing Naprosyn, Flexeril, Zofran, Prilosec, Medrox, and tramadol for pain relief.

Also reviewed is a utilization review report of July 11, 2013, in which the utilization reviewer denies prescriptions for Prilosec and Zofran.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for Cyclobenzaprine Hydrochloride 7.5mg #120:**

   Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
   The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter.

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Page 41, which is part of the MTUS.

   Rationale for the Decision:
   MTUS Chronic Pain Guidelines indicate that brief and short course of therapy involving cyclobenzaprine are tepidly endorsed. Usage of cyclobenzaprine as an addition to other agent is not, however, recommended by the MTUS Chronic Pain Medical Treatment Guidelines. According to the medical records provided for review the employee has demonstrated functional improvement in general by returning to regular duty work. Thus, a limited, shorter supply of Flexeril could have been supported here. **The request for Cyclobenzaprine Hydrochloride 7.5mg #120is not medically necessary and appropriate.**

2) **Regarding the request for Omeprazole DR 20mg #120:**

   Section of the Medical Treatment Utilization Schedule 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 are part of the MTUS, and the Official Disability Guidelines (ODG), which are not part of the MTUS.

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Page 69, which is a part of the MTUS.

Rationale for the Decision:
MTUS Chronic Pain Guidelines indicate that proton pump inhibitors such as omeprazole or Prilosec are indicated in the treatment of NSAID-induced dyspepsia, as appears to be present here. The attending provider has reported that the employee has developed dyspepsia in conjunction with Naprosyn usage. Per page 69 of the MTUS Chronic Pain Medical Treatment Guidelines, addition of omeprazole in this context is indicated and appropriate. **Therefore, the request for Omeprazole DR 20mg #120is medically necessary and appropriate.**

3) **Regarding the request for Ondansetron 8mg #60:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and the Official Disability Guidelines (ODG), which are not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Food and Drug Administration (FDA) indication found at the following website:
http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm271924.htm, which is not a part of the MTUS.

Rationale for the Decision:
The FDA indication states that ondansetron can be used to prevent nausea and vomiting caused by cancer, chemotherapy, radiation therapy, and/or surgery. According to the medical records provided for review the employee has reported nausea associated with cyclobenzaprine or Flexeril usage. This is not labeled, FDA-supported use. Nevertheless, given the employee's functional improvement, a variance for limited or reduced amount of Zofran to combat medication-induced nausea might have been supported; the 120-tablet supply requested, however, cannot, as this implies almost daily usage of ondansetron or Zofran for a non-FDA approved purpose. **The request for Ondansetron 8mg #60is 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.