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**Notice of Independent Medical Review Determination**

Dated: 10/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	4/30/2007
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003472

- 1) MAXIMUS Federal Services, Inc. has determined the request for Norco 325mg #240 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Robaxin 750mg #180 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Zantac 150mg #120 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Dendracin lotion 120ml **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for outpatient trigger point injection Trapezius **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 7/9/2013. 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 Norco 325mg #240 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Robaxin 750mg #180 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Zantac 150mg #120 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Dendracin lotion 120ml **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for outpatient trigger point injection Trapezius **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 9, 2013:

**Description of Alleged Injury:** Employee was driving bus back to Agency yard, when she was unable to stop at redlight, causing rear end chain reaction.

### 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 7/25/13)
- Utilization Review Determination from [REDACTED] (dated 7/9/13)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for Norco 325mg #240:**

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), Opioids for chronic pain, pg.80, 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.

Rationale for the Decision:

The employee sustained a work-related injury 4/30/2007 resulting in mostly right-sided neck pain causing frequency headaches with radiation of pain into the right upper extremity. The request is for Norco 325mg #240.

MTUS Guidelines recommend opioids for neuropathic pain that has not responded to first line recommendations with treatments and antidepressants and anticonvulsants, and note there were no trials for long-term use. There were virtually no studies of opioids for treatment of chronic lumbar pain, root pain with resultant neuropathy and note that for chronic back pain, opioids appear efficacious, but limited for short-term pain relief and long-term efficacy is unclear, but also appeared to be limited. Failure to respond to time-limited course of opioids has led to suggestion in reassessment and consideration of alternative therapy. As the employee appears to have been taking the Norco on a long-term, routine basis for complaints of low back pain with radiation of pain to the lower extremities, and chronic neck pain, and the guidelines recommend a trial of antidepressants or AEDs. There is no documentation that the employee has undergone a trial of antidepressants or anticonvulsants, and there is no documentation that the employee receives pain relief or functional improvement with the use of Norco. The request for Norco 325mg #240 **is not medically necessary and appropriate.**

**2) Regarding the request for Robaxin 750mg #180:**

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), Muscle Relaxants, pg.63, 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.

Rationale for the Decision:

The employee sustained a work-related injury 4/30/2007 resulting in mostly right-sided neck pain causing frequency headaches with radiation of pain into the right upper extremity. The request is for Robaxin 750mg #180.

MTUS Guidelines state that non-sedating muscle relaxants are recommended with caution as a second line option for short-term treatment of acute exacerbations in individuals with chronic low back pain. The patient appears to be taking the Robaxin on a routine, long-term basis, which does not meet California MTUS guideline recommendations. The request for Robaxin 750mg #180 **is not medically necessary and appropriate.**

**3) Regarding the request for Zantac 150mg #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), NSAIDs for chronic pain, pg.68-69, 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.

Rationale for the Decision:

The employee sustained a work-related injury 4/30/2007 resulting in mostly right-sided neck pain causing frequency headaches with radiation of pain into the right upper extremity. The request is for Zantac 150mg #120.

MTUS Guidelines recommend the use of a proton pump inhibitor for individuals older than 65 years of age with a history of peptic ulcer, GI bleeding, or perforation with use of concurrent ASA corticosteroids or an anti-inflammatory or high dose, multiple doses of NSAIDs. There is no documentation that the employee has a history of peptic ulcer, GI bleeding, perforation, or gastrointestinal upset with the use of naproxen, and the employee is noted to also be taking Prilosec. The request for Zantac 150mg #120 **is not medically necessary and appropriate.**

**4) Regarding the request for Dendracin lotion 120ml:**

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 111-112 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.

Rationale for the Decision:

The employee sustained a work-related injury 4/30/2007 resulting in mostly right-sided neck pain causing frequency headaches with radiation of pain into the right upper extremity. The request is for Dendracin lotion 120ml.

MTUS Guidelines state Guidelines state there is little to no research to support many topical analgesics and any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Also, clinical trials for this treatment modality were inconsistent, most studies were small, and of short duration, and topical NSAIDs are noted to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but not afterward, or diminishing over the next 2 week period. The employee is not noted to be treating for osteoarthritis and the main complaints of pain were at the lumbar spine and neck, and the California MTUS Guidelines state there is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. The requested Dendracin, which contains methyl salicylate, menthol, and benzocaine does not meet California MTUS Guideline recommendations. The request for Dendracin lotion 120ml **is not medically necessary and appropriate.**

**5) Regarding the request for outpatient trigger point injection Trapezius:**

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), Trigger point injections, Page 122, 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.

Rationale for the Decision:

The employee sustained a work-related injury 4/30/2007 resulting in mostly right-sided neck pain causing frequency headaches with radiation of pain into the right upper extremity. The request is for outpatient trigger point injection Trapezius.

MTUS Guidelines state that trigger point injections are recommended for myofascial pain syndrome when there is documentation of circumscribed trigger points with evidence on palpation of a twitch response, as well as referred pain and the symptoms have persisted for more than 3 months and ongoing stretching exercise, physical therapy, NSAIDs, and muscle relaxants have failed to control the pain when radiculopathy is not present on physical exam. Although the employee is noted to have trigger point injections to the neck and the head and neck, there is no documentation of findings of triggerpoints located in the left trapezius, right trapezius, the supraspinatus, or the levator scapula or radiation of pain. In addition, there is no indication the employee had been performing stretching exercises or had recently attended physical therapy without improvement. The request for outpatient trapezius trigger point injection **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  
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Oakland, CA 94612

/slm

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.