
Notice of Independent Medical Review Determination

Dated: 11/27/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/17/2013
Date of Injury: 1/15/2010
IMR Application Received: 7/29/2013
MAXIMUS Case Number: CM13-0004850

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Naproxen Sodium tablets 550mg #120 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Omeprazole delayed-release capsules 20mg #120 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Ondansetron ODT tablets 8 mg #30 times 2 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Medrox pain relief ointment 120gm times 2 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Hydrocodone 10mg/325mg #60 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Cyclobenzaprine Hydrochloride tablets 7.5mg #120 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 **Naproxen Sodium tablets 550mg #120 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Omeprazole delayed-release capsules 20mg #120 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Ondansetron ODT tablets 8 mg #30 times 2 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Medrox pain relief ointment 120gm times 2 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Hydrocodone 10mg/325mg #60 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Cyclobenzaprine Hydrochloride tablets 7.5mg #120 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 Pain Management 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 patient is a 64-year-old male who reported a work-related injury on 02/03/2011 as a result of injury to his left little finger. The patient subsequently was initially diagnosed with crush injury left small finger, laceration left small finger, open fracture left small finger, and possible digital nerve injury left small finger. The most recent clinical note submitted for review by the patient's primary treating physician [REDACTED] for his injuries is dated from 11/05/2012. The provider documents the patient presents with additional

complaints of cervical spine pain, bilateral shoulder pain, bilateral wrist pain, lumbar spine pain, and right lower extremity pain. The provider documents the patient has diagnoses of cervical discopathy, bilateral shoulder internal derangement, bilateral carpal tunnel syndrome, upper back pain referred from the cervical spine, lumbar discopathy with S1 radiculopathy per EMG, rule out internal derangement of the right ankle and status post right knee arthroscopic surgery as of 05/25/2012. The provider documented injecting the patient's right knee with Celestone and lidocaine. The provider documented the patient is in need of surgical interventions to the right knee. The provider documented the patient utilizes the following medication regimen, naproxen for inflammation 1 by mouth every 12 hours, cyclobenzaprine 7.5 mg 1 by mouth every 8 hours, Cidaflex 1 by mouth 3 times a day for joint pain, ondansetron 8 mg tab, omeprazole 20 mg tab 1 by mouth every 12 hours, and Medrox pain relief ointment for temporary relief of minor aches and muscle pain to be utilized up to every ID. The provider documented the medications provide the patient with temporary symptomatic relief and allow him to continue to function on a daily basis.

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 Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the retrospective request for Naproxen Sodium tablets 550mg #120:

Section of the Medical Treatment Utilization Schedule (MTUS) Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) guidelines, and the Official Disability Guidelines (ODG), which is not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 73, which is part of the MTUS.

Rationale for the Decision:

The current request previously received an adverse determination on 07/16/2013. The previous utilization review was not submitted, evidencing the rationale for the adverse determination. The most recent clinical note submitted for the current request is dated from 11/2012. The clinical notes did not evidence quantifiable efficacy as documented by a decrease in rate of pain on a VAS scale and increase in objective functionality as a result of the employee utilizing this current medication regimen for his multiple injury complaints. The Chronic Pain Medical Treatment Guidelines indicate, "The dose of naproxen may be increased to 1500 mg a day for limited periods when a higher level of analgesic/anti-inflammatory activity is required for up to 6 months." Guidelines do not support chronic utilization of anti-inflammatories due adverse side effects. **The**

retrospective request for Naproxen Sodium tablets 550mg #120 is not medically necessary and appropriate.

2) Regarding the retrospective request for Omeprazole delayed-release capsules 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 American College of Occupational and Environmental Medicine (ACOEM) guidelines, and the Official Disability Guidelines (ODG), which is not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 68-69, which are part of the MTUS.

Rationale for the Decision:

The current request previously received an adverse determination on 07/16/2013. The previous utilization review was not submitted, evidencing the rationale for the adverse determination. The current request is not supported, as the most recent clinical note assessing the employee's subjective complaints and objective findings of symptomatology is dated from 11/05/2012. Without a recent assessment of the employee's current medical condition, the employee's medication regimen cannot be supported. Chronic Pain Medical Treatment Guidelines indicate, "Prilosec is recommended for patients at intermediate risk for gastrointestinal events and no cardiovascular disease." Review of the clinical note did not indicate the employee has complaints of gastrointestinal upset to support the requested intervention. **The retrospective request for Omeprazole delayed-release capsules 20mg #120 is not medically necessary and appropriate.**

3) Regarding the retrospective request for Ondansetron ODT tablets 8 mg #30 times 2:

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 American College of Occupational and Environmental Medicine (ACOEM) guidelines, and the Official Disability Guidelines (ODG), which is not part of 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 Official Disability Guidelines (ODG), Antiemetics (for opioid nausea), which is not part of MTUS.

Rationale for the Decision:

The current request previously received an adverse determination on 07/16/2013. The previous utilization review was not submitted, evidencing the rationale for the adverse determination. The current request cannot be

supported, as the most recent clinical note is dated from 11/2012. The clinical notes lack evidence of documentation of the employee's reports of efficacy with use of this medication for his nausea complaints. Furthermore, Official Disability Guidelines indicate, "Studies of opioid adverse effects, including nausea and vomiting are limited to short-term duration, less than 4 weeks, and have limited application of long-term use." It is unclear how long the employee has been utilizing this medication for nausea complaints; however, at this point in his treatment, if nausea is continuing with the utilization of opioids, a different treatment plan should be assessed. **The retrospective request for Ondansetron ODT tablets 8 mg #30 times 2 is not medically necessary and appropriate.**

4) Regarding the retrospective request for Medrox pain relief ointment 120gm times 2 :

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 American College of Occupational and Environmental Medicine (ACOEM) guidelines, and the Official Disability Guidelines (ODG), which is not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 111, which is part of the MTUS.

Rationale for the Decision:

The current request previously received an adverse determination on 07/16/2013. The previous utilization review was not submitted, evidencing the rationale for the adverse determination. The most recent clinical note submitted for review in support of the employee's medication regimen is dated from 11/2012. The provider fails to document the employees's specific reports of efficacy with this medication regimen as noted by a decrease in rate of pain on a VAS scale and increase in objective functionality. Chronic Pain Medical Treatment Guidelines indicate, "Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety." Given the lack of recent documentation indicating the employee's current pain complaints, recent active treatment modalities utilized and reports of efficacy with this medication, the request for Medrox pain relief ointment 120 gm times 2 is not medically necessary. **The retrospective request for Medrox pain relief ointment 120gm times 2 is not medically necessary and appropriate.**

5) Regarding the retrospective request for Hydrocodone 10mg/325mg #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 American College of Occupational and Environmental Medicine (ACOEM) guidelines, and the Official Disability Guidelines (ODG), which is not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 78, which is part of the MTUS.

Rationale for the Decision:

The current request previously received an adverse determination on 07/16/2013. The previous utilization review was not submitted, evidencing the rationale for the adverse determination. The clinical notes submitted for review lack evidence of a recent assessment of the employee, both objectively and subjective. Chronic Pain Medical Treatment Guidelines indicate, "4 domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychological /psychosocial functioning, and the appearance of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities in daily living, adverse side effects, and aberrant drug-taking behavior). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." **The retrospective request for Hydrocodone 10mg/325mg #60 is not medically necessary and appropriate.**

6) Regarding the retrospective request for Cyclobenzaprine Hydrochloride tablets 7.5mg #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 American College of Occupational and Environmental Medicine (ACOEM) guidelines, and the Official Disability Guidelines (ODG), which is not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 41-42, which is part of the MTUS.

Rationale for the Decision:

The current request previously received an adverse determination on 07/16/2013. The previous utilization review was not submitted, evidencing the rationale for the adverse determination. The clinical documentation submitted for review fails to evidence a recent assessment of the employee, both objectively and subjectively. Chronic Pain Medical Treatment Guidelines indicate, "Cyclobenzaprine is recommended as an option using a short course of therapy." The employee has been utilizing this medication chronic in nature. **The retrospective request for Cyclobenzaprine Hydrochloride tablets 7.5mg #120 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.