

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



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**Notice of Independent Medical Review Determination**

Dated: 12/2/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/31/2013  
Date of Injury: 4/26/2011  
IMR Application Received: 8/6/2013  
MAXIMUS Case Number: CM13-0007895

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **one (1) toxicology-urine drug screen - date of service: 7/16/2013 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Sinralyne- PM Quantity: one (1) is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **topical Amitriptyline/ Dextromethorphan/Tramadol cream quantity 120 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. 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 **one (1) toxicology-urine drug screen - date of service: 7/16/2013 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Sinralyne- PM Quantity: one (1) is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **topical Amitriptyline/ Dextromethorphan/Tramadol cream quantity 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 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.

### **Expert Reviewer Case Summary:**

This patient is a 47-year-old male who reported an injury on 04/26/2011. The documentation submitted for review indicates that prior treatment of the patient has consisted of epidural steroid injections, which were performed on 03/10/2012 and 06/30/2012, which provided the patient only temporary relief. Furthermore, notes indicate that the patient currently has intermittent use of Norco and continued use of oral and topical medications. Notes indicate that the patient has a history of lumbar injury with resulting radiculopathy. Furthermore, notes indicate that the patient's last urine toxicology was authorized in 12/2012. Complaints of the patient are of low back pain and right lower extremity pain verbalized as 5/10. Notes indicate that current consideration is for review of a toxicology urine screen performed on 07/16/2013, as well as a request for Sinralyne PM and a topical compounded medication containing amitriptyline, dextromethorphan, and tramadol.

### **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 one (1) toxicology-urine drug screen - date of service: 7/16/2013:**

#### 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, pgs. 94-95, which is part of the MTUS, and the Official Disability Guidelines (ODG), chronic pain chapter, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pgs. 76-78, which is part of the MTUS.

#### Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate the recommendation for drug testing as an option, using a urine drug screen to assess for the presence or use of illegal drugs, as well as for steps to take before therapeutic trial of opioids, and for ongoing management of patients on opioids. Furthermore, drug testing may be used as part of a screening process for the risk of addiction. Clinical notes from 07/16/2013 indicate that the employee was seen for a pain management evaluation. Chief complaint of the employee was of continued low back pain and right lower extremity pain. Notes indicate that the employee was tested for medications currently to monitor compliance with pharmacological regimen, as well as to identify any possible drug interactions related to multiple prescribing physicians. The employee was tested for benzodiazepines, methadone, barbiturates, OxyContin, hydrocodone, propoxyphene, opioids, and buprenorphine. However, there is no clear documentation indicating that the employee was suspected of aberrant drug-taking behavior, or to indicate that the employee was not taking his medications as prescribed. Furthermore, there was a lack of documentation indicating a previous urine toxicology screen was used for the employee's treatment. **The retrospective request for one (1) toxicology-urine drug screen - date of service: 7/16/2013 is not medically necessary and appropriate.**

## 2) Regarding the request for Sintralyn- PM Quantity: one (1):

### 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 Official Disability Guidelines (ODG), which is not a part of the MTUS.

1. 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 [Sintralyn-PM oral : Uses, Side Effects, Interactions, Pictures ... www.webmd.com/.../drug-155489-Sintralyn-PM+oral.aspx?...Sintralyn...](http://www.webmd.com/.../drug-155489-Sintralyn-PM+oral.aspx?...Sintralyn...)

### Rationale for the Decision:

There is a lack of information regarding this medication. A search for peer reviewed clinical literature concerning Sintralyn PM provided no sufficient information regarding the ingredients, indications for use, drug interactions, or contraindications. Furthermore, while it is noted that Sintralyn PM has a dose of 5mg/20mg/460mg in capsule form. There is no clear indication of what the specific ingredients may be used to treat. Therefore, medical necessity is not supported due to the lack of quality clinical information regarding Sintralyn PM. **The request for Sintralyn- PM Quantity: one (1) is not medically necessary and appropriate.**

## 3) Regarding the request for topical Amitriptyline/ Dextromethorphan/Tramadol cream quantity 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, page 49, and the Chronic Pain Medical Treatment Guidelines, pg. 111, which are part of the MTUS.

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

### Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine their efficacy or safety. Furthermore, they are recommended primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug or drug class that is not recommended, likewise, is not recommended. While the California MTUS Guidelines do not specifically address dextromethorphan, amitriptyline or tramadol, guidelines do indicate that many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists,

adrenergic receptor agonists, adenosine, cannabinoids, cholinergic receptor agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. Guidelines further recommend that there is little to no research to support the use of many of these agents. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. More over, while the documentation submitted for review indicates that the employee is recommended for use of this compounded analgesic, there is a lack of documentation indicating specific therapeutic goals of the medication, as well as a lack of indication of efficacy of this medication for the employee. There is a lack of documentation indicating numeric pain scales and increase in the employee's abilities to undertake activities of daily living as a result of the use of this medication. **The request for Topical Amitriptyline /Dextromethorphan /Tramadol cream quantity 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/ejf

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.