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## Independent Medical Review Final Determination Letter

[REDACTED]  
[REDACTED]  
[REDACTED]

December 23, 2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/25/2013  
Date of Injury: 11/1/2000  
IMR Application Received: 8/16/2013  
MAXIMUS Case Number: CM13-0013581

Dear [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, and is licensed to practice in Texas. 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 physician 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 disputed items/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 54-year-old female who reported an injury on 11/01/2000. The patient is currently diagnosed with lumbar radiculopathy, chronic pain syndrome, chronic pain-related insomnia, myofascial syndrome, neuropathic pain, prescription narcotic dependence, chronic pain-related depression, and tension headaches. She was most recently evaluated by Dr. [REDACTED] on 09/17/2013. She rated her pain 2/10 with medications and 7/10 without medications. She did report relief with a cortisone injection. Objective findings were not provided at that time. Treatment plan included continuation of current medications.

### IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **1. Trazodone 50mg #60 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Chronic Pain Chapter, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Official Disability Guidelines state insomnia treatment is recommended based on etiology. Trazodone is one of the most commonly prescribed agents for insomnia. Improvements in sleep onset may be offset by negative next day effects, such as ease of wakening. Tolerance may develop and rebound insomnia has been found after discontinuation. There is less evidence to support the use of sedating antidepressants for insomnia. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. As per the clinical notes submitted, the patient has been prescribed trazodone since at least 10/2012 with

continued complaints of severe insomnia. Modified certifications have been provided in previous utilization review reports to allow for weaning. Without documentation of objective functional response, the ongoing use cannot be determined as medically appropriate. There is also no indication as to why this employee would not benefit from non-pharmacological treatment or an over-the-counter product as opposed to a prescription medication. Based on the clinical information received and the Official Disability Guidelines, the request is non-certified. **The request for Trazodone 50mg #60 is not medically necessary and appropriate.**

## **2. Sintralyn #60 is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Chronic Pain Chapter, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Sintralyn PM is a melatonin gamma-aminobutyric acid herbal compound. Official Disability Guidelines state melatonin has been shown to have analgesic benefits in patients with chronic pain. Empirically supported treatment of insomnia includes stimulus control, progressive muscle relaxation, and paradoxical intention. Treatments that are thought to be efficacious include sleep restriction, biofeedback, and multifaceted cognitive behavioral therapy. The employee continues to report complaints of depression, anxiety, and insomnia. Evidence of objective improvement was not provided. There is no indication as to why this employee would not benefit from the use of an over-the-counter product as opposed to a prescription medication. The medical necessity for the requested medication has not been established. Based on the clinical information received, the request is non-certified. **The request for Sintralyn #60 is not medically necessary and appropriate.**

## **3. Flexeril 10mg #90 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for pain), pgs. 63-66, which are part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state muscle relaxants are recommended as a non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. Cyclobenzaprine is recommended only for a short course of therapy, and is not recommended to be used for longer than 2 to 3 weeks. As per the clinical notes submitted, the employee has utilized Flexeril beyond the recommended period. Based on the clinical information received and the California MTUS Guidelines, the continuation of this medication does not appear warranted at this time. **The request for Flexeril 10mg #90 is not medically necessary and appropriate.**

#### **4. Prilosec 20mg #30 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, pgs. 68-69, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitors. As per the clinical notes submitted, the employee does not currently meet criteria for the use of a proton pump inhibitor. There is also no indication as to why this employee would not benefit from an over-the-counter product as opposed to a prescription medication. The medical necessity has not been established, therefore, the request is non-certified. **The request for Prilosec 20mg #30 is not medically necessary and appropriate.**

#### **5. Medrox patches #120 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pgs. 111-113, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Current evidence-based treatment guidelines do not recommend the use of salicylate topicals for the treatment of neuropathic pain. Medrox contains capsaicin, which is recommended only as an option in patients who have not responded or are intolerant to other treatments. California MTUS Guidelines further state any compounded product that contains at least 1 drug or drug class that is not recommended, is not recommended as a whole. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified. **The request for Medrox patches #120 is not medically necessary and appropriate.**

#### **6. X-ray of the thoracic spine with 2 views is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004), Low Back Complaints, pgs. 303-305, which are part of the MTUS, and the Official Disability Guidelines (ODG), Low Back Chapter, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS/ACOEM Practice Guidelines state lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. Official Disability Guidelines state indication for plain x-rays include thoracic or lumbar spine trauma, uncomplicated low back pain with exceptional factors, and myelopathy. As per the clinical notes submitted, the patient does not currently meet any of the above-mentioned criteria for a thoracic spine x-ray. The patient recently underwent a bone scan on 06/27/2013, which revealed the presence of a mild increase in uptake at the T5 level, which likely represented degenerative changes. As the bone scan does not suggest the presence of metastatic disease, further imaging is not clinically warranted at this time. Based on the clinical information received, the request is non-certified. **The request for X-ray of the thoracic spine with 2 views is not medically necessary and appropriate.**

**7. Flector patch 1.3% #60 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pgs. 111-113, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Diclofenac is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. NSAIDs are recommended for a short term, including 4 to 12 weeks. Based on the increased risk profile with Flector patch, prior long-term use, and lack of support for use in cases of chronic musculoskeletal pain, proceeding with the use of Flector patch for treatment does not appear medically necessary for this patient at this time. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified. **The request for Flector patch 1.3% #60 is not medically necessary and appropriate.**

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.

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