

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/5/2013

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/16/2013
Date of Injury:	5/28/2003
IMR Application Received:	9/24/2013
MAXIMUS Case Number:	CM13-0017372

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Gralise 600mg #90 with 5 refills is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Viibryd 40mg, #30 with 5 refills is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 9/24/2013 disputing the Utilization Review Denial dated 8/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **Gralise 600mg #90 with 5 refills is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Viibryd 40mg, #30 with 5 refills is 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 Internal 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 patient is a 59 yo female who sustained an injury on 05/28/03. The mechanism of injury was not provided. Diagnoses include post laminotomy pain syndrome with spondylolisthesis and instability; myelopathy with untable gait and frequent falls; gastritis; major depression, hallux valgus/hammertoe deformity, spinal stenosis with right lumbar radicular symptoms. She is being followed by a neurologist, pain management specialist, and a psychologist. Per MRI of the lumbar spine, she has severe spinal stenosis to L3-L4 above the prior surgical procedures. There was hardware at L4-L5 with grade I anterolisthesis. She is treated with medical therapy with Oxycontin, Wellbutrin XL, Buspar, Ativan, Prozac and Clonazepam. The treating provider has recommended Gralise 600mg #90 with 5 refills and Viibryd 40mg #30 with 5 refills.

### **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 Gralise 600mg #90 with 5 refills:**

The Medical Treatment Guidelines 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. 16-21, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 13-14, which is part of the MTUS.

Rationale for the Decision:

The recommended medication, Gralise, is medically necessary for the treatment of the employee's condition. According to the clinical documentation, the employee has neuropathic pain on the basis of the diagnosis of post laminotomy pain syndrome. The medication is part of the employee medical regimen. Per MTUS guidelines, antiepilepsy medications are a first line treatment for neuropathic pain. A recommended trial period for an adequate trial of Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. The employee has been prescribed the medication and the medical record documents positive response. Medical necessity has been documented. **The request for Gralise 600mg #90 with 5 refills is medically necessary and appropriate.**

**2) Regarding the request for Viibryd 40mg, #30 with 5 refills :**

The Medical Treatment Guidelines 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. 16-21, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 13-16, which is part of the MTUS.

Rationale for the Decision:

The requested medication, Viibryd 40mg, is medically necessary for the treatment of the employee's condition. Viibryd is an antidepressant in the group of drugs called selective reuptake inhibitors (SSRIs). The employee is under the care of a psychologist and has depression as part of the chronic pain condition. The employee has been treated with prior antidepressants without success. The medication Viibryd is indicated in the treatment of chronic pain as suggested in the guidelines. The MTUS guidelines indicate that the main role of SSRIs may be addressing the psychological symptoms associated with chronic pain. The employee is awaiting evaluation by a psychiatrist. Medical necessity for the medication, Viibryd, has been established. **The request for Viibryd 40mg, #30 with 5 refills is 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

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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.