

## Independent Medical Review Final Determination Letter

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Dated: 12/27/2013

<b>IMR Case Number:</b>	CM13-0017798	<b>Date of Injury:</b>	05/21/2007
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/08/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/28/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED]		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
URINE DRUG SCREEN- MEDICALLY CERTIFIED BY PA, PT 2X4 TO LUMBAR SPINE, MEDICATION REVIEW- FIORICET, SUBUTEX, TRAMADOL, CELEBREX, PRILOSEC, ELAVIL, COLACE, VALIUM, TESTOSTERONE, MEDROX PATCHES, TGHOT OINTMENT, VIAGRA-NOT MEDICALLY CERTIFIED BY PA			

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: PARTIAL OVERTURN. This means we decided that some (but not all) 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]  
[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 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 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 underlying date of injury in this case is 5/21/2007. This patient has multiple treating diagnoses, including lumbar radiculopathy status post lumbar fusion, chronic pain syndrome, and traumatic arthropathy status post left thumb carpometacarpal joint with trapeziectomy, cervical radiculopathy, chronic pain related insomnia, opioid dependence, myofascial syndrome, and chronic pain related anxiety and depression. The treating physician notes indicate that the patient has reported increasing pain into his hips and upper legs. In the past the patient reports he had benefitted from physical therapy when he had flares of symptoms. The patient reports pain referred to the hips and upper thighs. The treating physician recommended another course of physical therapy to develop a home exercise program. Additionally an authorization was requested for continued Fioricet for headaches, Subtext for severe pain, tramadol for breakthrough pain, Celebrex, Prilosec, Elavil, Colace, Valium, Testosterone, Medrox patches, and TGH ointment, physical therapy medically necessary.

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

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

**1. Physical therapy two times a week for four weeks for the lumbar spine is 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 Chronic Pain Medical Treatment Guidelines Physical Medicine, pgs 89-99, which is part of the MTUS.

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines section on physical medicine states "Allow for fading of treatment frequency plus active self-directed home physical medicine." The medical records provided for review reflects that this is a complex chronic case in which the employee is being treated with extensive polypharmacy for which these medications have been noncertified. Review of an active home independent rehabilitation program as an alternative to a polypharmacy would be strongly supported by the guidelines. **The request for physical therapy two times a week for four weeks for the lumbar spine is medically necessary and appropriate**

## **2. Fioricet 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 Chronic Pain Medical Treatment Guidelines, Barbiturate Containing Analgesics, pg. 23, which is part of the MTUS

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines section on Barbiturate Containing Analgesics, states "Not recommended for chronic pain . . . Potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy due to the barbiturate constituents." The medical records provided for review do not contain an alternate rationale for this medication. **The request for Fioricet is not medically necessary and appropriate.**

## **3. Subutex 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 Chronic Pain Medical Treatment Guidelines Buprenorphine and Page 26 and Opioids, Discontinuing Treatment, Page 79

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guideline regarding Buprenorphine states "Recommended for treatment of opiate addiction. Also recommended as an option for treating chronic pain, especially after detoxification in patients with a history of opiate addiction." Continued use of this medication, particularly in a polypharmacological setting with side effects of testosterone deficiencies and erectile dysfunction, is not supported by the guidelines. Rather, the Chronic Pain Medical Treatment Guidelines section on opioids/discontinuing treatment, "(a) If there is overall improvement in function, unless there are extenuating circumstances." Based on the medical records provided for review, due to the employee lack of functional improvement, as well as side effects from opioid use, the guidelines do not support continued use of Subutex. **The request for Subutex is not medically necessary and appropriate.**

#### **4. Tramadol is 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 Chronic Pain Medical Treatment Guidelines Tramadol, pg.113, which is part of the MTUS.

The Physician Reviewer's decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Tramadol states that this medication is "A centrally acting synthetic opioid and is not recommended as a first-line oral analgesic." Based on the medical records provided and the chronic nature of the employee's pain and desire to wean the employee from substantially potent opioids, producing side effects including Subutex, the guidelines would support tramadol as a second-line medication with substantially less risk of physical dependence. **The request for Tramadol is medically necessary and appropriate.**

#### **5. Celebrex 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 Chronic Pain Medical Treatment Guidelines, Antiinflammatory Medications, pg. 22, which is part of the MTUS.

The Physician Reviewer's decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on anti-inflammatory medications states "Anti-inflammatories are the traditional first-line of treatment to reduce pain so activity and functional restoration can resume. Note that Cox-2 inhibitors may be considered if the patient has a risk of gastrointestinal complications, but not for the majority of patients." The medical records provided for review do not include a rationale for selecting Celebrex as opposed to a traditional anti-inflammatory medication. **The request for Celebrex is not medically necessary and appropriate.**

#### **6. Prilosec 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 Chronic Pain Medical Treatment Guidelines, Anti-inflammatory Medications and Gastrointestinal Symptoms, pg. 68, which is part of the MTUS.

The Physician Reviewer's decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on anti-inflammatory medications and gastrointestinal symptoms states the clinician should "Determine if the patient is at risk for gastrointestinal events." The medical records provided for review do not include a clear indication of specific risk factors for gastrointestinal events. **The request for Prilosec is not medically necessary and appropriate.**

## **7. Elavil is 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 Chronic Pain Medical Treatment Guidelines, Tricyclic Antidepressants, pg.122, which is part of the MTUS.

The Physician Reviewer's decision rationale: California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Tricyclic antidepressants, states "Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated." This medication is a first line medication opposed to other drug classes which have been recommended for non certification. **The request for Elavil is medically necessary and appropriate.**

## **8. Colace 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 Chronic Pain Medical Treatment Guidelines, Opioids/Initiating Therapy, pg. 77, which is part of the MTUS.

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines section on Opioids/Initiating Therapy, states "Prophylactic treatment of constipation should be initiated." Given that multiple opioids have been recommended for non certification, it follows that Colace is no longer indicated. **The request for Colace is not medically necessary and appropriate.**

## **9. Valium 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 Chronic Pain Medical Treatment Guidelines, Benzodiazepines, pg.24, which is part of the MTUS.

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines section on Benzodiazepines states "Not recommended for long term use because long-term efficacy is unproven and there is a risk of dependence . . . Chronic benzodiazepines are the treatments of choice in very few conditions." The guidelines therefore do not support this medication for long-term use. The medical records provided for review do not include an alternate rationale for the use of benzodiazepines. **The request for Valium is not medically necessary and appropriate.**

## **10. Testosterone 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 Chronic Pain Medical Treatment Guidelines, Opioids/When to Discontinue Opioids, pg. 79, which is part of the MTUS.

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines section on Opioids/When to Discontinue Opioids, states "b) Continuing pain with evidence of intolerable Adverse Effects." Given erectile dysfunction as a complication of opioids, the treatment guidelines would recommend discontinuing opioids with lack of functional effect rather than adding testosterone and Viagra for erectile deficiency and erectile dysfunction. **The request for testosterone is not medically necessary.**

#### **11. Medrox Patches 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 Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg. 111, which is part of the MTUS.

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines section on Topical Analgesics recommends "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." The medical records provided for review do not include such information to support an indication for ongoing topical medication use at this time. **The request for Medrox patches is not medically necessary and appropriate.**

#### **12. TGHot ointment 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 Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg. 111, which is part of the MTUS.

The Physician Reviewer's decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Topical Analgesics recommends "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." The medical records provided for review do not provide such information to support an indication for ongoing topical medication use at this time. **The request for TGHot ointment is not medically necessary and appropriate.**

#### **13. Viagra 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 Chronic Pain Medical Treatment Guidelines, Opioids/When to Discontinue Opioids, pg. 79, which is part of the MTUS.

The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines section on Opioids/When to Discontinue Opioids, states "(b) Continuing pain with evidence of intolerable Adverse Effects." Given erectile dysfunction as a complication of opioids, the treatment guidelines would recommend discontinuing opioids with lack of functional effect rather than adding testosterone and Viagra for erectile deficiency and erectile dysfunction. **The request for Viagra is not medically necessary and appropriate.**

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