
Notice of Independent Medical Review Determination

Dated: 12/11/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/12/2013
Date of Injury: 1/28/2004
IMR Application Received: 9/3/2013
MAXIMUS Case Number: CM13-0019854

- 1) MAXIMUS Federal Services, Inc. has determined the request for **one urine drug screen is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Fosamax 70mg #4 with one refill between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Clonidine 0.2mg #30 between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Pristiq 50mg #30 between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Arthrotec 75mg #90 between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **one prescription of TGHot 180mg between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 9/3/2013 disputing the Utilization Review Denial dated 8/12/2013. 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 **one urine drug screen is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Fosamax 70mg #4 with one refill between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Clonidine 0.2mg #30 between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Pristiq 50mg #30 between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Arthrotec 75mg #90 between 7/8/2013 and 9/30/2013 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **one prescription of TGHot 180mg between 7/8/2013 and 9/30/2013 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 Internal Medicine & Pulmonary Disease 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 63-year-old male who reported an injury on 01/28/2004. The patient was injured due to a fall. The patient was ultimately diagnosed with having reflex sympathetic dystrophy (RSD) in the right upper extremity. The patient underwent an imaging study of the right shoulder on 11/27/2012 that revealed there was mild osteoarthritis in the acromioclavicular joint coupled with a rotator cuff tear. The patient's pain was managed with medications and psychological treatment. The patient also received a corticosteroid injection, physical therapy, and acupuncture therapy.

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
 - Employee/Employee Representative
 - Provider

1) Regarding the request for one urine drug screen:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Urine Drug Screen page 43 and page 77, which are part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines indicate a urine drug screen as a step to take before beginning a therapeutic trial of opioids. The medical records submitted for review do indicate that the employee has previously taken opioid medication. However, the most recent submitted documentation does not indicate the employee is currently using opioids to manage chronic pain. Therefore a urine drug screen would not be indicated to monitor the employee for compliance. Additionally, there is no documentation of suspicion of illicit drug use. **The request for one urine drug screen is not medically necessary and appropriate.**

2) Regarding the request for Fosamax 70mg #4 with one refill between 7/8/2013 and 9/30/2013:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Bisphosphonates page 25, which is part of the MTUS.

Rationale for the Decision:

The clinical documentation submitted for review does provide evidence that the employee has been on this medication for an extended period of time. The MTUS Chronic Pain Guidelines do recommend Fosamax to produce

improvement of pain, pressure tolerance, and joint mobility in the treatment of chronic regional pain syndrome (CRPS.) It is noted within the documentation that the employee is diagnosed with CRPS. However, the clinical documentation does not provide evidence to support the efficacy of this medication. There is no functional benefit established as result of this medication. **The request for Fosamax 70 mg #4 with one refill between 07/08/2013 and 09/30/2013 is not medically necessary and appropriate**

3) Regarding the request for Clonidine 0.2mg #30 between 7/8/2013 and 9/30/2013:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the California Chronic Pain Medical Treatment Guidelines, which is part of the 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 Section on Pain, Chronic Regional Pain Syndrome, and Medications.

Rationale for the Decision:

The Official Disability Guidelines do not recommend the use of clonidine in the treatment of chronic regional pain syndrome as it is not supported by current literature. However, the medical records provided for review do indicate that the employee has been on this medication for an extended duration of time. The submitted documentation does not provide any indication of increased functional benefit as a result of this medication. **The request for Clonidine 0.2 mg #30 between 07/08/2013 and 09/30/2013 is not medically necessary and appropriate**

4) Regarding the request for Pristiq 50mg #30 between 7/8/2013 and 9/30/2013:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section on Antidepressants for Chronic Pain, which is part of the MTUS. The Expert Reviewer also based his/her decision on the Official Disability Guidelines section on Mental Illness and Stress, Antidepressants for treatment of Major Depressive Disorder, which is not part of the MTUS, and the RX List, <http://www.rxlist.com/pristiq-drug/indications-dosage.htm>, which is not part of the MTUS.

Rationale for the Decision:

MTUS guidelines indicate the need for documentation of functional improvement for continuation of medications. The employee is being treated for depression and has received psychiatric treatment. The clinical documentation submitted for review does indicate the employee has been on this medication for an extended duration of time. The clinical documentation does not provide any evidence of functional benefits resulting from use of this medication. There are no clinical objective findings to support that this employee's symptoms are controlled by this medication. **The request for Pristiq 50 mg #30 between 07/08/2013 and 09/30/2013 is not medically necessary and appropriate**

5) Regarding the request for Arthrotec 75mg #90 between 7/8/2013 and 9/30/2013:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Non-Steroidal Anti-Inflammatory Drugs pages 67-69, which is part of the MTUS, and RX List, <http://www.rxlist.com/arthrotec-drug.htm>, which is not part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines recommend non-steroidal anti-inflammatory drugs (NSAID) as a second-line treatment. Arthrotec is a NSAID with stomach protection. However, it is indicated within the clinical documentation provided for review that the employee has been on this medication for an extended duration. The clinical documentation does not provide any objective functional findings to support the efficacy of continuation with this medication. Additionally, there is no indication of the need for a stomach protector. **The requested Arthrotec 75 mg #90 between 07/08/2013 and 09/30/2013 is not medically necessary and appropriate**

6) Regarding the request for one prescription of TGHot 180mg between 7/8/2013 and 9/30/2013:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

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

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 did not find any evidence based criteria for his/her decision.

Rationale for the Decision:

This medication is not addressed in any evidence-based guidelines. Exhaustive on-line research failed to identify the requested medication. As the efficacy and safety of this medication cannot be established, continued use would not be indicated. **The request for one prescription of TGHot 180mg between 7/8/2013 and 9/30/2013 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

/MCC

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.