
Notice of Independent Medical Review Determination

Dated: 9/9/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/3/2013
Date of Injury: 11/18/2005
IMR Application Received: 7/10/2013
MAXIMUS Case Number: CM13-0001092

- 1) MAXIMUS Federal Services, Inc. has determined the request for medication management Qty: 1 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for psychotherapy visits Qty: 24 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Alprazolam 0.25mg Qty: 30.00 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Hydroxyzline 25mg Qty 120.00 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Lunesta 3mg Qty: 60.00 **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Topiramate 25mg Qty: 30.00 **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Prevacid 40mg Qty: 30.00 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/10/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/11/2013. 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 medication management Qty: 1 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for psychotherapy visits Qty: 24 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Alprazolam 0.25mg Qty: 30.00 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Hydroxyzine 25mg Qty 120.00 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Lunesta 3mg Qty: 60.00 **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Topiramate 25mg Qty: 30.00 **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Prevacid 40mg Qty: 30.00 **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 Psychiatry, 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013

“The patient is a 47-year old female who reported an injury on 11/18/2005. The patient was noted to be running out of Lidoderm patches and Hydroxyzine. Treatment plan was noted to include Alprazolam 0.25mg 1 as needed not to exceed 2 in 24 hours. Hydroxyzine 25mg 1 four times a day, Lunesta 3mg 2 at bedtime, Cymbalta 60mg 1 daily, Topiramate 25mg 1 daily with plan to titrate to appropriate dose.

“Per request psychiatric report dated 1/25/2013, the patient was noted to have passive suicidal ideation with reasonably good insight and non-impaired judgment. The patient was diagnosed with major depressive disorder, pain disorder associated with general medical condition and with psychological factors.

“Per physician’s report dated 2/25/2013, a request is made for Prevacid.

“Per agreed medical evaluation dated 4/1/2013, the patient’s medications were listed as Cymbalta, Lidoderm patches, Lunesta, Tramadol, Flexeril, and Lisinopril. Physical exam noted tenderness in the subscapular area and decreased range of motion in the right shoulder. The patient was noted to utilize a cane for ambulation with an AFO. The patient was unable to perform walking on toes or walking on heels. Tenderness was noted in the spine, paraspinal muscles, and sacroiliac joints. Sensation was noted to be decreased in the left lower extremity. Muscle strength was noted to be 0/5 in the left anterior tibial extensor hallucis longus, peroneals, gastrocnemius, and soleus.

“Per physician’s progress report dated 4/8/13, objective findings included the patient’s mood to be improving slightly and the patient reported making changes to her routine in attempts to become more functional.

“Per physician’s progress report dated 4/26/13, the patient’s mood was noted to continue to show improvement.

“Per clinical note dated 5/30/13, the patient reported a very good weekend. Objective findings included improved mood, clear and logical thinking, and the patient reported being able to be out and about more. The patient reported ongoing pain but was showing overall improvement.

“Per clinical note dated 6/10/13, the patient reported fatigue and difficulty getting out of bed. The patient’s mood was noted to be affected by quality of sleep and the patient’s fatigue was noted to be associated to lack of CPAP use as directed.”

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 for Independent Medical Review (received 7/10/13)
- Utilization Review Determination (dated 7/3/13)
- Official Disability Guidelines (ODG) current version, Pain Chapter, Insomnia treatment section
- Chronic Pain Medical Treatment Guidelines (2009), Psychological treatment, pages 101-102
- Chronic Pain Medical Treatment Guidelines (2009), Benzodiazepines, page 24
- Chronic Pain Medical Treatment Guidelines (2009), Section Other Antiepileptic Drugs, Topiramate, pg 21
- Chronic Pain Medical Treatment Guidelines (2009), Section NSAIDs, GI symptoms & cardiovascular risk, pg 68
- Medical Records from [REDACTED], D.O. (dated 6/18/12-7/15/13)
- Medical Records from [REDACTED], M.D. (dated 8/2/12-4/1/13)
- PR-2 Reports from [REDACTED], D.O. (dated 5/21/12-7/15/13)

- Progress notes from [REDACTED], MD, MSA (dated 6/1/12-6/4/12)
- Progress notes from [REDACTED], CPO (dated 8/9/12-8/22/12)

1) Regarding the request for medication management Qty: 1 :

Medical Treatment Guideline(s) 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), 2nd Edition, (online edition), Chapter 7, pg. 127, a medical treatment guideline (MTG), not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the American College of Occupational and Environmental Medicine (ACOEM), (online edition), Chapter 7, pg. 163, a medical treatment guideline (MTG), not part of the Medical Treatment Utilization Schedule (MTUS) applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 11/18/2005. Medical records submitted and reviewed indicate treatment has included various medications. A medical report dated 1/25/13 indicates the employee was diagnosed with major depressive disorder and pain disorder associated with general medical condition with psychological factors. A request was submitted for medical management Qty: 1.

ACOEM Guidelines state, “consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinee’s fitness for return to work.” The medical records submitted and reviewed indicate consistent observed mental status findings over an extended period of time of depressed mood with flat/constricted/blunted affect, irritability and anxiety that are indicative of a Major Depressive disorder to varying degrees. Medical management for this impairment is appropriate. The request for medical management Qty: 1 is medically necessary and appropriate.

2) Regarding the request for psychotherapy visits Qty: 24 :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Psychological treatment, pgs. 101-102, part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 11/18/2005. Medical records submitted and reviewed indicate treatment has included various medications. A medical report dated 1/25/13 indicates the employee was diagnosed with major depressive disorder and pain disorder associated with general medical condition with psychological factors. A request was submitted for psychotherapy visits Qty: 24.

MTUS Chronic Pain guidelines recommend, with evidence of functional improvement, a total of up to 13-20 psychotherapy visits over 13-20 weeks in the treatment of depression. The requested number of visits exceeds the guideline recommendations. The request for psychotherapy visits Qty. 24 is not medically necessary and appropriate.

3) Regarding the request for Alprazolam 0.25mg Qty: 30.00:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Benzodiazepines, page 24, part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Benzodiazepines, pg. 14, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 11/18/2005. Medical records submitted and reviewed indicate treatment has included various medications. A medical report dated 1/25/13 indicates the employee was diagnosed with major depressive disorder and pain disorder associated with general medical condition with psychological factors. A request was submitted for Alprazolam 0.25mg Qty: 30.00.

MTUS Chronic Pain guidelines indicate there is a lack of evidence to support long-term efficacy of benzodiazepines (Alprazolam). There is a risk of dependency, and long-term use may actually increase anxiety. Guidelines limit the use of this medication to 4 weeks. The medical records reviewed indicate this medication has been prescribed in excess of 4 weeks, which exceeds guidelines recommendations. The request for Alprazolam 0.25mg Qty: 30.00 is not medically necessary and appropriate.

4) Regarding the request for Hydroxyzine 25mg Qty 120.00:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Hydroxyzine Package Insert, Indications Section, not part of the Medical Treatment Utilization Schedule (MTUS) or medical treatment guideline (MTG), which is a nationally-recognized

professional standard. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS or medical treatment guideline applicable and relevant to the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 11/18/2005. Medical records submitted and reviewed indicate treatment has included various medications. A medical report dated 1/25/13 indicates the employee was diagnosed with major depressive disorder and pain disorder associated with general medical condition with psychological factors. A request was submitted for Hydroxyzine 25mg Qty: 120.00.

Hydroxyzine is indicated for symptomatic relief of anxiety, but there are currently no long term studies to support the use of Hydroxyzine for the treatment of anxiety beyond four months. A mental status exam dated 1/25/13 indicates the employee was experiencing anxiety and depression. However, a review of the medical records submitted indicates Hydroxyzine had been prescribed for over four months. The request for Hydroxyzine 25mg Qty: 120.00 is not medically necessary.

5) Regarding the request for Lunesta 3mg Qty: 60.00:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) current version, Pain Chapter, Insomnia Treatment Section. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 11/18/2005. Medical records submitted and reviewed indicate treatment has included various medications. A medical report dated 1/25/13 indicates the employee was diagnosed with major depressive disorder and pain disorder associated with general medical condition with psychological factors. A request was submitted for Lunesta Qty: 60.00.

Official Disability Guidelines state Lunesta is not recommended for use beyond 35 days. A review of the medical records indicates the employee was not properly using the Continuous Positive Airway Pressure (CPAP) machine at night, which would contribute to poor sleep and daytime fatigue. Additionally, the records reviewed lacked documentation to support improved sleep patterns while taking Lunesta. The request for Lunesta Qty: 60.00 is not medically necessary and appropriate.

6) Regarding the request for Topiramate 25mg Qty: 30.00:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Section Other Antiepileptic Drugs, Topiramate, pg. 2, part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Section Other Antiepileptic Drugs, Topiramate, pg. 21, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 11/18/2005. Medical records submitted and reviewed indicate treatment has included various medications. A medical report dated 1/25/13 indicates the employee was diagnosed with major depressive disorder and pain disorder associated with general medical condition with psychological factors. A request was submitted for Topiramate 25mg Qty: 30.00

MTUS Chronic Pain guidelines indicate Topiramate has been shown to have variable efficacy and is considered for use for neuropathic pain when other anticonvulsants fail. A review of the medical records submitted indicates the employee experiences neuropathic pain. However, there is lack of documentation to indicate the employee has benefited from the use of this medication. The request for Topiramate 25mg Qty: 30.00 is not medically necessary and appropriate.

7) Regarding the request for Prevacid 40mg Qty: 30.00:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Section NSAIDs, GI symptoms & cardiovascular risk, pg 111, of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Section NSAIDs, GI symptoms & cardiovascular risk, pg. 68, of the MTUS applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 11/18/2005. Medical records submitted and reviewed indicate treatment has included various medications. A medical report dated 1/25/13 indicates the employee was diagnosed with major depressive disorder and pain disorder associated with general medical condition with psychological factors. A request was submitted for Prevacid 40mg Qty: 30.00

MTUS Chronic Pain guidelines recommend the use of a proton pump inhibitor (Prevacid) in patients at risk for gastrointestinal events. There was a lack of

documentation in the records reviewed to indicate objective evidence of a gastrointestinal disorder that would require the use of this medication. The request for Prevacid 40mg Qty: 30:00 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th 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.