

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 11/1/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/17/2013
Date of Injury: 1/27/1995
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003385

- 1) MAXIMUS Federal Services, Inc. has determined the request for Baclofen 10mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Pilocarpine 5mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Protonix 40mg **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Triamcinolone 0.1% cream **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Lyrica 75mg **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Klonopin 0.5mg **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Ambien 10mg **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for Icy hot medicated 5% patch **is not medically necessary and appropriate.**

- 9) MAXIMUS Federal Services, Inc. has determined the request for Soma 350mg **is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm 5 % patch **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 Baclofen 10mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Pilocarpine 5mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Protonix 40mg **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Triamcinolone 0.1% cream **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Lyrica 75mg **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Klonopin 0.5mg **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Ambien 10mg **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for Icy hot medicated 5% patch **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for Soma 350mg **is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm 5 % patch **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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 17, 2013:

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SUMMARY OF RECORDS:

The claimant is a 63-year-old female with a date of injury on January 27, 1997. The mechanism of injury is not identified.

She is diagnosed with a post lumbar laminectomy syndrome with degenerative disc disease lumbar spine and chronic back pain, status post laminectomy/discectomy L5-S1. She also has knee pain. She is on 15 different medications.

I reviewed a report dated June 25, 2013. Her activity level is decreased. She is not trying any other therapies for pain relief. Her medications are working well. She has not been able to sleep because her Ambien was not approved. She is on 16 medications. On examination she appears to be in pain. Her gait is antalgic. She uses a cane. There is no scoliosis or asymmetry or abnormal curvature of the lumbar spine. Range of motion is restricted with flexion at 55° limited by pain and extension limited to 13° by pain. She has hypertonicity and tenderness on both sides of the lumbar spine. Lumbar facet loading was positive bilaterally. Straight leg raise was negative. Reflexes were symmetrical. She has pain with motion testing of the right knee in flexion. There was tenderness over the lateral and medial joint line. There is tenderness over the patella. Muscle strength testing is limited by pain. In one part of the report he states that the knee reflexes are 1/4 on both sides. In another part of report he states the reflexes are 2/4 at the knees bilaterally. He also states ankle jerk is 1/4 on both sides but then goes on to state the ankle reflexes were absent. Of course this makes no sense. It is noted that she was permanent and stationary. There is no reference to a pain contract or random urine drug testing.

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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 7/25/13)
- Utilization Review Determination from [REDACTED] (dated 7/17/13)
- Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Baclofen 10mg :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Baclofen, pg. 46, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee

hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Baclofen 10mg.

The guidelines recommend Baclofen for the treatment of spasticity and muscle spasms related to multiple sclerosis and spinal cord injuries. There is a lack of documentation indicating that the employee has one of these conditions and a lack of physical exam findings to support the addition of Baclofen to the employee's medication regimen. Furthermore, the employee is concurrently taking Soma, and there is no rationale for the use of two muscle relaxants. **The request for Baclofen 10mg is not medically necessary and appropriate.**

2) Regarding the request for Pilocarpine 5mg :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the monthly prescribing reference, page 22 in the June 2013 edition, which is not 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 MedlinePlus, (online edition), Pilocarpine, <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a608039.html>.

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Pilocarpine 5mg .

The medical evidence indicates that Pilocarpine is used to treat dry mouth caused by radiotherapy and/or Sjogren's syndrome. The documentation submitted for review fails to demonstrate that the employee has dry mouth complaints. In addition, there is no indication that there was consideration for reducing medication regimen if the employee's current medications are causing dry mouth symptoms. The records reviewed do not document side effects from the existing medication regimen **The request for Pilocarpine 5mg is not medically necessary and appropriate.**

3) Regarding the request for Protonix 40mg :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI Symptoms & Cardiovascular Risk, which is part of the MTUS.

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

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Protonix 40mg.

The guidelines recommend the use of Protonix for patients at risk for gastrointestinal events. The records reviewed do not document side effects from the existing medication regimen and there is no indication that the employee has any current gastrointestinal symptoms or is at high risk for developing gastrointestinal events. **The request for Protonix 40mg is not medically necessary and appropriate.**

4) Regarding the request for Triamcinolone 0.1% cream :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the 2013 Monthly prescribing reference, pg. 81, which is not part of 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 MedlinePlus, (online edition), Triamcinolone Topical.

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint

disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Triamcinolone 0.1% cream.

The medical evidence indicates that Triamcinolone is used to treat itching, redness, dryness, crusting, scaling, inflammation, and disorders of various skin conditions. The submitted medical records fail to demonstrate that the employee has any current physical examination findings to support the use of this cream and the employee has denied side effects from current medication regimen. **The request for Triamcinolone 0.1% cream is not medically necessary and appropriate.**

5) Regarding the request for Lyrica 75mg :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Pregabalin (Lyrica), pg. 19-20, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Lyrica 75mg.

The guidelines recommend Lyrica for the treatment of neuropathic pain. The submitted medical records fail to report that the employee has neuropathic pain complaints. Furthermore, the records note the employee indicates improvement with the medication regimen; however, this is not demonstrated objectively within the available clinical notes. **The request for Lyrica 75mg is not medically necessary and appropriate.**

6) Regarding the request for Klonopin 0.5mg :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, pg. 23, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Klonopin 0.5mg.

The guidelines do not recommend long-term use of benzodiazepines and state that use is limited to four weeks. The submitted medical records indicate that the employee has been using Klonopin for greater than four weeks. Additionally, there is a lack of any significant documented efficacy with this medication. **The request for Klonopin 0.5mg is not medically necessary and appropriate.**

7) Regarding the request for Ambien 10mg :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Zolpidem, which is not 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 (ODG), Pain Chapter, Zolpidem (Ambien®).

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee

hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Ambien 10mg.

The guidelines do not support use of this medication for more than six weeks for the treatment of insomnia. The submitted medical records note complaints of insomnia: however, the employee has been taking this medication for greater than six weeks. In addition, the records do not demonstrate significant benefit with use of this medication. **The request for Ambien 10mg is not medically necessary and appropriate.**

8) Regarding the request for Icy hot medicated 5% patch :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

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

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Icy hot medicated 5% patch.

The guidelines state that topical medications are largely experimental. The submitted medical records fail to demonstrate the efficacy of this particular patch. **The request for Icy hot medicated 5% patch is not medically necessary and appropriate.**

9) Regarding the request for Soma 350mg :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma), pg. 29, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Soma 350mg.

The guidelines note that long-term use of Soma is not recommended. The submitted medical records indicate long-term use of this medication. There is a lack of documentation of any significant physical exam findings to support the requested medication. **The request for Soma 350mg is not medically necessary and appropriate.**

10)Regarding the request for Lidoderm 5 % patch :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

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

Rationale for the Decision:

The employee sustained a work-related injury on 1/27/95. The submitted medical records note chronic low back pain and right knee pain. The employee's diagnoses include spinal/lumbar degenerative disc disease, post laminectomy syndrome, right knee pain, post-traumatic patellar chondromalacia of right knee, major depressive disorder with history of suicidal ideation and degenerative joint disease, right knee. The submitted medical records note that prior treatment has included surgery, oral medications, right knee cortisone injections, physical therapy, psychotherapy, a front-wheeled walker, a lumbar corset, right knee hinge brace, wrist brace, hypnotherapy, an orthopedic bed, cognitive behavioral therapy, a hot and cold ice machine, electrical stimulation unit, epidural steroids injections and trigger point injections. A request has been submitted for Lidoderm 5% patch.

The guidelines state that Lidoderm is recommended for neuropathic pain and diabetic neuropathy. The documentation submitted for review fails to

demonstrate subjective complaints for neuropathic pain and there is a lack of documentation of significant pain relief with ongoing use of Lidoderm patched. **The request for Lidoderm 5% patch 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

/srb

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.