MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 11/18/2013

[redacted]

[redacted]

Employee:	[redacted]
Claim Number:	[redacted]
Date of UR Decision:	7/15/2013
Date of Injury:	8/18/1999
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004513

1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Lidoderm 5% patch #60 is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Nexium DR 20mg #60 is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Omeprazole DR 20mg #100 is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Ondansetron HCl 4mg #10 is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Voltaren Gel 1% #2 tube is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Zolpidem Tartrate 10mg #30 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/7/2013. 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 **Lidoderm 5% patch #60 is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Nexium DR 20mg #60 is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **Omeprazole DR 20mg #100 is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **Ondansetron HCl 4mg #10 is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request for **Voltaren Gel 1% #2 tube is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the request for **Zolpidem Tartrate 10mg #30 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 Family Practice 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:
This claimant is a 50-year-old female with multiple complaints, including neck pain radiating to the bilateral upper extremities and bilateral shoulder pain, left greater than right. On 01/09/2012, she was seen in clinic. At that time, it was noted she remained stable with medications and has periods of anxiety, depression, and irritability with increasing pain. She was taking hydrocodone 20 mg – 30 mg a day for her pain and was also on Cosamine, Ambien, and Nexium, as well a Zomig for headaches. Her mood was depressed and her affect was depressed at that time. Plan was to keep her on the current treatment regimen. Exam was performed [redacted]*. She returned to pain management clinic on 03/20/2012 with continued complaints of pain. Pain was rated at 8/10 at that time. She stated she complained that cervical epidural steroid injections did not help and actually increased her pain. She also reported anxiety with daily living limitations. Objectively, she was in moderate distress and range of motion was moderately decreased in the cervical spine.*

Sensory and motor exam revealed no significant changes. Plan was to give her a B12 injection for her acute pain. She had previously been described Anaprox DS 550 twice a day. She was seen in clinic by [redacted] on 06/22/2012 with continued complaints of pain to the neck and lumbar spine. She was given an intramuscular injection with Toradol and vitamin B12 complex at that time. On 03/27/2013, she returned to pain clinic, again indicating she had low back pain and pain was rated at 2/10 with medications and 9/10 without medications. Physical therapy was ordered and she was continued on medications. On 04/10/2013, a primary treating physician's supplemental report was submitted by [redacted], indicating the claimant's records were reviewed and her current complaints at that time included back pain. She also had been diagnosed with a lumbar strain. On 06/03/2013, she was seen back in clinic by [redacted]. It was noted then that she continued to complain of pain. This was to the neck and upper extremities. She was given a Toradol and B12 injection at that time. Plan was to continue the current treatment plan, including medications. On 07/11/2013, [redacted] submitted a primary treating physician's progress report. This report indicates the claimant continued to report significant neck pain with numbness and tingling to the bilateral upper extremities and reported increased symptomatology in her low back with achiness, stiffness, and difficulty sleeping. She had reduced range of motion in her cervical spine with muscle spasms noted. Lumbar spine revealed tenderness, spasms, and tightness, and straight leg raise was positive. She was given 2 injections, 1 a Toradol injection and 1 a B12 injection, at that time for her diagnoses of cervical discopathy and stenosis and bilateral upper extremity overuse syndrome. Plan was to continue home exercises and oral medications and topical creams. On 07/17/2013, [redacted] submitted an appeal to utilization review denial. This report indicates the claimant was already manifesting symptoms of gastric upset which placed her at risk to develop complications.

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 Lidoderm 5% patch #60:**

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Pain Chapter, which is not part of the MTUS.

The Expert Reviewer based his decision on the Chronic Pain Medical Treatment Guidelines, Lidoderm Patch, pgs. 56-57, Topical analgesics, pgs. 111-113, which are part of the MTUS.

Rationale for the Decision:
The last clinical note for this employee is dated 07/11/2013. It was noted then that the employee reported significant neck pain with numbness and tingling to the bilateral upper extremities, as well as low back pain. However, pain was not objectively identified on a VAS scale to objectively document how much pain the employee is actually in. Previous determination dated 07/12/2013 non-certified this request, indicating that evidence based guidelines recommend the use of Lidoderm patches as a second line agent in the treatment of neuropathic pain. It was noted, in this case, the request was not certified as there was no clear documentation noting the failure of first line agents used in the management of neuropathic pain. The submitted records for this review also fail to indicate that neuropathic pain has been treated by first line agents. Guidelines further state that this is not a first line treatment except for postherpetic neuralgia and the records do not indicate this employee has postherpetic neuralgia. Guidelines further indicate that further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. Furthermore, MTUS Chronic Pain Guidelines discuss topical analgesics and indicate they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. **The request for Lidoderm 5% patch #60 is not medically necessary and appropriate.**

2) **Regarding the request for Nexium DR 20mg #60:**

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, which is part of the MTUS.

The Expert Reviewer based his decision on the Chronic Pain Medical Treatment Guidelines, NSAIDS, GI Symptoms and Cardiovascular Risk, pgs 68-69, which are part of the MTUS.

Rationale for the Decision:
Medical records provided for this review fail to indicate clinically that the employee has gastric irritability. The appeal letter by [redacted] states that the employee is at risk for developing complications and was already manifesting symptoms of gastric upset. The clinical notes submitted for this review fail to confirm that, as there is lack of documentation of complaints of GERD or gastrointestinal upset on multiple clinical notes, and there is failure to document past gastrointestinal events such as ulcers or GERD. Chronic Pain Medical Treatment Guidelines indicate that patients should weigh the indications for NSAIDs against both GI and cardiovascular risk factors and determine if the patient is at risk for gastrointestinal events. This would include age 65 years or older, history of peptic ulcer, GI bleeding or perforation, or concurrent use of ASA, corticosteroids or an anticoagulant, or high dose multiple NSAIDs. Patients with no risk and no cardiovascular disease can take a non-selective NSAID. Patients at intermediate risk for gastrointestinal events and no cardiovascular disease can take a non-selective NSAID with either a PPI (proton pump inhibitor) or misoprostol, or a COX-2 selective agent.

Records indicate this employee is 50 years of age and the records do not indicate cardiovascular disease as a comorbid diagnosis and do not indicate other significant risk factors. The guideline criteria have not been met. **The request for Nexium DR 20mg #60is not medically necessary and appropriate.**

3) **Regarding the request for Omeprazole DR 20mg #100:**

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, which is part of the MTUS.

The Expert Reviewer based his decision on the Chronic Pain Medical Treatment Guidelines, NSAIDS, GI Symptoms pgs. 68-69, which are part of the MTUS..

Rationale for the Decision:
Medical records provided for this review fail to indicate clinically that the employee has gastric irritability. The appeal letter by [redacted] states that the employee is at risk for developing complications and was already manifesting symptoms of gastric upset. The clinical notes submitted for this review fail to confirm that, as there is lack of documentation of complaints of GERD or gastrointestinal upset on multiple clinical notes, and there is failure to document past gastrointestinal events such as ulcers or GERD. Chronic Pain Medical Treatment Guidelines indicate that patients should weigh the indications for NSAIDs against both GI and cardiovascular risk factors and determine if the patient is at risk for gastrointestinal events. This would include age 65 years or older, history of peptic ulcer, GI bleeding or perforation, or concurrent use of ASA, corticosteroids or an anticoagulant, or high dose multiple NSAIDs. Patients with no risk and no cardiovascular disease can take a non-selective NSAID. Patients at intermediate risk for gastrointestinal events and no cardiovascular disease can take a non-selective NSAID with either a PPI (proton pump inhibitor) or misoprostol, or a COX-2 selective agent. Records indicate this employee is 50 years of age and the records do not indicate cardiovascular disease as a comorbid diagnosis and do not indicate other significant risk factors. The guideline criteria have not been met. **The request for Omeprazole DR 20mg #100 is not medically necessary and appropriate.**

4) **Regarding the request for Ondansetron HCl 4mg #10:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his decision on the Official Disability Guidelines (ODG), Medication Chapter, which is not part of the MTUS.

Rationale for the Decision:
This medication is used as an anti-emetic or anti-nausea medication. ODG, Medication Chapter states this medication is not recommended for nausea and vomiting secondary to chronic opioid use, but is recommended for acute use, per FDA approved indications. This specific drug is known as a serotonin 5-HT3 receptor antagonist and is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use and acute use is FDA approved for gastroenteritis. The submitted records do not indicate this employee has nausea and vomiting secondary to chemotherapy or radiation treatment or has recently undergone surgery. The most recent records fail to indicate gastroenteritis. Medical records submitted for this review fail to indicate a clear clinical use for this medication and do not indicate, as stated previously, this employee is in the immediate postop phase or has nausea and vomiting secondary to chemo or radiation treatment. Guidelines do not support this medication for nausea and vomiting secondary to chronic opioid use. **The request for Ondansetron HCL 4mg #10 is not medically necessary and appropriate.**

5) **Regarding the request for Voltaren Gel 1% #2 tube:**

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), which is not part of the MTUS.

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

Rationale for the Decision:
Medical records provided for this review fail to get a clear clinical indication for this medication. The records do not indicate the employee's pain is in a joint that is amenable to this medication, such as the extremities, and do not indicate significant pain. As noted previously, the employee's pain scale is not objectively identified on a VAS scale to document the amount of pain. Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain where trials of antidepressants and anticonvulsants have failed. Guidelines further state that these medications may be useful for chronic musculoskeletal pain, but there are no long term studies of their effectiveness or safety. Indications would include osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amendable to topical treatment, and it is recommended for short term use. The submitted records fail to indicate this employee has significant osteoarthritis of the affected lower extremity joints amenable to this treatment and fail to indicate a failed first line treatment. **The request for Voltaren Gel 1% #2 tube is not medically necessary and appropriate**.

6) **Regarding the request for Zolpidem Tartrate 10mg #30 :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his decision on the Official Disability Guidelines (ODG), Medication Chapter, which is not part of the MTUS.

Rationale for the Decision:
This medication is also known as Ambien. This medication is a prescription short acting non-benzodiazepine hypnotic which is approved for the short term, usually 2 weeks to 6 weeks, treatment of insomnia. ODG, Medication indicates that, while sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long term use. There were concerns that they may increase pain and depression over the long term. The medical records submitted for this review fail to indicate the efficacy of this medication and fail to indicate a rationale for continuing this medication. The records do not indicate this employee has significant sleep issues for which this medication is indicated. The records do not indicate this medication should be used for the long term use. As such, this request is not supported by guidelines, not supported by previous determination, and not supported by the records. **The request for Zolpidem Tartrate 10mg #30 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

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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.