

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/25/2013
Date of Injury: 7/31/2001
IMR Application Received: 7/29/2013
MAXIMUS Case Number: CM13-0004910

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: UPHOLD. This means we decided that none 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]

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 Internal Medicine, 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 patient is a 56-year-old male who sustained an occupational injury on 07/31/2001. The patient's compensable injuries resulted in the need for treatment of chronic lumbar spine pain with a laminectomy approximately 5 years ago. In addition to the patient's lumbar surgery, the patient has also been treated with physical therapy, oral medications, and activity modification. The most recent documentation from 07/19/2013 indicates the patient has subjective complaints of increasing numbness in his right lower extremity with stable back pain. Objective documentation from that day indicates the patient has a slowed antalgic gait; however, he is able to ambulate without assistance. The patient's current medication regimen include Suboxone 8/2 mg ½ tablet 6 times daily, gabapentin 300 mg 3 tablets daily, and tizanidine 4 mg 1 tablet daily, as well as Lunesta 3 mg 1 by mouth at bedtime.

IMR DECISION(S) AND RATIONALE(S)

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

1. Suboxone 8mg-2mg #90 with five refills is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Buprenorphine, pages 26-27 and page 77, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS indicates buprenorphine is recommended for the treatment of opioid addiction, as well an option for chronic pain, especially after detoxification in patients who have a history of opioid addiction. While the documentation provided clearly indicates the patient has a longstanding history of chronic low back pain secondary to his compensable injury, guidelines also indicate that patients on chronic opioid therapy should have ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The documentation provided does indicate the patient has been using Suboxone for greater than 1 year with the documentation provided showing evidence of pain relief, however, guideline criteria also indicates patients should be followed at approximately 1 ½ to 2 months intervals for the documentation of this ongoing management, especially when the patient is on multiple schedule medications. While the patient may benefit from the continued use of Suboxone, the request as written with 90 tablets and 5 refills is not supported secondary to the need for more frequent follow up and assessment with documentation on most recent visit indicating a return visit in 90 days (not 180) . Subsequent refills should only be given after verification of the 4A's at each follow up visit in accordance with guidelines. As such, the request for Suboxone 8 mg-2 mg #90 with 5 refills is not medically necessary and is therefore, non-certified.

2. Gabapentin 300mg #90 with five refills is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antiepilepsy drugs, pages 16-17, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS recommends the use of antiepileptic drugs for neuropathic pain or pain due to nerve damage. Furthermore, it indicates that after initiation of treatment of these medications there should be documentation of pain relief and improvement in function, as well as documentation of side effects incurred with use. The continued use of this medication depends on improved outcomes versus tolerability of adverse effects. While the documentation presented for review does indicate the patient has ongoing complaints of low back pain with increasing numbness in his right lower extremity, there is a lack of evidence to suggest that documentation of pain relief and improvement in function as well as documentation of side effects incurred with use was confirmed. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. There is a lack of documentation found in the file indicating that review of the amount of pain relief and improvement in function as well as documentation of

side effects incurred with the specific drug use took place. As such, the request for gabapentin 300 mg #90 with 5 refills is excessive in nature as the patient is required to follow up at regular intervals for documentation of pain relief as well as side effects. Additional refills should only be given after this review is completed. Therefore, additional refills beyond the scheduled follow-up (which is scheduled for 90 days per the most recent office note) should be determined at that time. Due to the lack of documentation that the ongoing management of this medication's efficacy and safety has taken place combined with the excessive nature of the request, gabapentin 300 mg #90 with 5 refills cannot be supported and is therefore non-certified.

3. Lunesta 3mg #30 with five refills is not medically necessary and appropriate.

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

The Physician 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), Insomnia treatment, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Official Disability Guidelines indicate that pharmacological agents should only be used in the treatment of insomnia after careful evaluation of potential causes of sleep disturbance. Primary insomnia is generally addressed pharmacologically. A specific component of insomnia should be addressed with sleep onset, sleep maintenance, sleep quality and next day functioning. Furthermore, non-benzodiazepine sedative hypnotics are considered the first line medications for insomnia. This class includes Lunesta. While the documentation submitted for review does indicate the patient has been receiving Lunesta 3 mg to be taken 1 tablet at bedtime in the management of poor sleep hygiene, there is a lack of documentation in the file consistent with criteria requirements that patients specific components of insomnia, i.e. sleep onset, sleep maintenance, sleep quality and next day functioning, have been addressed as per guidelines. Furthermore, guidelines indicate that this medication has not been studied for use past 6 months. As such, the request for Lunesta 3 mg #30 with 5 refills would far exceed the guideline criteria. Given the lack of documentation of the ongoing assessment of this patient's sleep components as well as the excess of nature of this request, Lunesta 3 mg #30 with 5 refills does not appear to be medically necessary and is therefore non-certified.

4. Tizanidine HCL 4mg #60 with five refills is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 63, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS indicates that anti-spasticity or antispasmodic drugs are recognized with the unlabeled use for low back pain. Guidelines also indicate that while muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility in most low back pain cases they show no benefit beyond NSAIDs for pain and overall improvement. Furthermore, efficacy appears to diminish over time and prolonged use of some of the medications in this class

may lead to dependence. Therefore, the use of this medication is only recommended for short-term. Given that the specific request is for tizanidine HCL 4 mg #60 with 5 refills, this would far exceed the guideline criteria of short-term use. As such, this request cannot be supported and is therefore non-certified.

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.

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[REDACTED]

[REDACTED]