
Notice of Independent Medical Review Determination

Dated: 11/25/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/22/2013
Date of Injury: 5/15/2003
IMR Application Received: 8/1/2013
MAXIMUS Case Number: CM13-0005686

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Lyrica 75mg #60 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ambien 10mg #30 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20mg #30 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Amitriptyline 25mg is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Fioricet #30 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Lidoderm #30 is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #120 is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/11/2013. 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 **Lyrica 75mg #60 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ambien 10mg #30 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20mg #30 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Amitriptyline 25mg is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Fioricet #30 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Lidoderm #30 is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #120 is 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 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 60-year-old female who reported injury on 05/15/2013. The mechanism of injury was the patient was washing a shower, picked up a floor mat and twisted and experienced a pop in her back. The patient is noted to complain of low back pain radiating to the left leg, behind the thigh area, left calf and at times to the foot. The examination of the lumbar spine revealed tenderness to palpation over the midline lumbar spine, bilateral paraspinal muscles, and the left sciatic notch, and left gluteus. The sensory examination revealed decreased sensation to light touch over the left ankle, foot, and toes. The patient's diagnoses were stated to be chronic lumbar spondylosis with herniated disc and radiculopathy, concordant pain at L4-5 and L5-S1 per discogram, bilateral S1 radiculopathy, depression, stress, gastritis, and cephalgia.

The treatment was noted to be Lyrica 75 mg #60, Ambien 10 mg #30, Prilosec 20 mg #30, amitriptyline 25 mg, Fioricet #30, Lidoderm #30, and Norco 10/325 #120.

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 Lyrica 75mg #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 (2009), which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pgs.16, 19, 99, which is a part of MTUS.

Rationale for the Decision:

CA MTUS Guidelines recommend Lyrica for neuropathic pain due to nerve damage. The medical records submitted for review indicate the examination dated 07/18/2013 revealed the employee had low back pain with radiating pain to the left leg, behind the thigh area, left calf and at times to the left foot. The record indicate the employee had a trial of Gabapentin, which was discontinued due to extreme drowsiness, as well as trials of other SNRIs including Cymbalta and these were discontinued due to side effects including severe nausea and dizziness. However, the employee is noted to be taking Lyrica 75 mg twice a day for neuropathic pain, with 40% to 50% improvement in pain with current medications and notes functional improvement. **The request for Lyrica 75mg #60 is medically necessary and appropriate.**

2) Regarding the request for Ambien 10mg #30:

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) Online Version, which is not a 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 the Official Disability Guidelines(ODG).

Rationale for the Decision:

ODG recommend Ambien for short-term use, usually 2 to 6 weeks for treatment of insomnia. Clinical documentation submitted for review failed to provide that the employee had difficulty sleeping. Additionally, it failed to provide the length of time the employee has been on the medication and given documentation that the patient has previously been on the medication, the employee's response to prior therapy with the medication. **The request for Ambien 10mg #30 is not medically necessary and appropriate.**

3) Regarding the request for Prilosec 20mg #30:

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 (2009), which is a part of MTUS.

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

Rationale for the Decision:

CA MTUS Guidelines recommend proton pump inhibitors (PPIs) for patients at intermediate risk for gastrointestinal events and no cardiovascular disease. Clinical documentation submitted for review indicates the employee has been experiencing gastritis, dyspepsia, and GERD symptoms. The employee is also noted to experience gastrointestinal (GI) side effects to the medications. However, it fails to include documentation of the efficacy of this medication for the relief of symptoms. **The request for Prilosec 20mg #30 is not medically necessary and appropriate.**

4) Regarding the request for Amitriptyline 25mg:

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 (2009), which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 13, which is part of the MTUS.

Rationale for the Decision:

CA MTUS Guidelines recommend Amitriptyline as a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Clinical documentation submitted for review dated 08/07/2013 revealed the employee has between a 40% to 50% improvement in pain with current medications. The employee is noted to have tenderness in the midline lumbar spine from L1 through L5 and tenderness in the bilateral paralumbar musculature along with decreased range of motion and a positive straight leg raise. The documentation submitted with the request for Amitriptyline indicates that the employee is using the medication for

neuropathic pain. **The request for Amitriptyline 25mg is medically necessary and appropriate.**

5) Regarding the request for Fioricet #30:

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 (2009), which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pgs. 23, 27, which is a part of MTUS.

Rationale for the Decision:

CA MTUS Guidelines do not recommend Fioricet for chronic pain. Clinical documentation submitted for review fails to include the employee's indications for the medication and it failed to provide the efficacy of the medication for the employee. **The request for Fioricet #30 is not medically necessary and appropriate.**

6) Regarding the request for Lidoderm #30:

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) Online Version, Chronic Pain section.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 56-57, which is a part of MTUS.

Rationale for the Decision:

CA MTUS Guidelines recommend Lidoderm for localized peripheral pain after there has been evidence of a trial of first line therapy including tricyclic, SNRI, antidepressants, or AED such as Gabapentin or Lyrica. Clinical documentation submitted for review indicates the employee is taking Lyrica and Amitriptyline, and it is noted that the Lidoderm and Lyrica are controlling the employee's pain by approximately 40% to 50%. The employee rates the pain at a 5/10 with use of medication, and without the medication at 9/10. It was noted that the employee is able to participate in activities of daily living and light exercise and stretching programs with the use of the medication. However, the clinical documentation submitted for review fails to include that the employee had failed a trial of Lyrica prior to the addition of Lidoderm, and fail to establish the efficacy of the Lidoderm and Lyrica together. **The request for Lidoderm is not medically necessary and appropriate.**

7) Regarding the request for Norco 10/325mg #120:

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 (2009), which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pgs. 78, 91, which is a part of MTUS.

Rationale for the Decision:

CA MTUS Guidelines recommend Norco for pain. Additionally, it states that ongoing monitoring include patient analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Clinical documentation submitted for review indicates the employee has pain rated a 5/10 with the use of medication, without medication at 9/10. The employee notes a 40% to 50% improvement in pain with current medications. The employee notes functional improvement including ability to participate in activities of daily living and light exercise and stretching programs with the medications. The records also documents that the employee was counseled on the side effects of the medications. **The request for Norco 10/325 mg #120 is 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

/sce

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.