

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/18/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/1/2013  
Date of Injury: 9/9/2005  
IMR Application Received: 8/8/2013  
MAXIMUS Case Number: CM13-0008481  
Treatment(s) in Dispute Listed on IMR Application:  
Terazosin 1MG #30 with two refills; Lunesta 3MG #30 with two refills ;  
Cymbalta 60MG #30 with two refills ;Methadone 10MG #360 ;Dilaudid 8MG #180  
Lyrica 200MG #90 with two refills ;Lexapro 20MG #30 with two refills  
Prevacid 30 MG #30 with two refills

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 Cardiology, has a fellowship trained in Cardiovascular Disease and is licensed to practice in Texas. 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from the employee
- No medical records were submitted by Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

### 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 61-year-old male who reported an injury on 09/09/2005. Current diagnoses include shoulder pain, knee pain, and RSD of the lower limb. The patient was most recently seen by Dr. [REDACTED] on 09/16/2013 for complaints of unchanged pain level and poor sleep quality. Current medications included Lunesta, Lyrica, Cymbalta, Lidoderm patch, Lexapro, terazosin, Prevacid, methadone, Dilaudid, Nuvigil, Zofran, Senokot, Androderm, Wellbutrin, and hydromorphone. Objective findings included depressed mood, unsteady gait, swelling of the right knee, restricted range of motion with tenderness to palpation of the right knee, tenderness to palpation over the medial joint line, and normal sensation. Treatment plan included continuation of current medications with slow tapering.

### IMR DECISION(S) AND RATIONALE(S)

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

**1. Terazosin 1MG #30 with two refills is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence based criteria for its decision.

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 Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Diabetes Chapter, Online edition, which is not part of MTUS.

The Physician Reviewer's decision rationale:

The Official Disability Guidelines indicate that antihypertension therapy is recommended after lifestyle modifications have been trialed. Terazosin is listed as a second line option for hypertensive therapy. As per the clinical notes submitted, there is no evidence of a failure to respond to first, second, third, or fourth edition medications prior to the initiation of second line therapy. There is also no evidence of a failure to respond to lifestyle modifications. The medical necessity for the requested medication has not been established based on the clinical information received and the Official Disability Guidelines. Therefore, the request is non-certified. **The request for Terazosin 1MG #30 with two refills is not medically necessary and appropriate.**

**2. Lunesta 3MG #30 with two refills is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence based criteria for its decision.

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 Physician Reviewer based his/her decision on Official Disability Guidelines (ODG), Chronic Pain Chapter, Online Edition, which is not part of MTUS.

The Physician Reviewer's decision rationale:

The Official Disability Guidelines indicate that insomnia treatment is recommended based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. Suggestions for improved sleep hygiene include waking at the same time every day, maintaining a consistent bedtime, exercising regularly, performing relaxation activities prior to bedtime, keeping the room quiet and cool, avoiding watching the clock, avoiding caffeine and nicotine for at least 6 hours before bedtime, only drinking in moderation, and avoiding napping. As per the clinical notes submitted, the employee continues to complain of poor sleep quality at each office visit despite the ongoing use of this particular medication. There is no indication as to why this employee would not benefit from non-pharmacological treatment or an over the counter medication as opposed to a prescription product. Satisfactory response to treatment has not been indicated. The medical necessity has not been established; therefore, the request is non-certified. **The request for Lunesta 3MG #30 with two refills is not medically necessary and appropriate.**

**3. Cymbalta 60MG #30 with two refills is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Section Antidepressants for chronic pain, pg. 13-16, which is part of MTUS, and Official Disability Guidelines (ODG), Pain chapter, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 13-16, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or

contraindicated. Cymbalta is FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. It is recommended as a first line option for diabetic neuropathy. There is no high quality evidence reported to support the use of Cymbalta for lumbar radiculopathy. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessment. As per the clinical notes submitted, the employee has been prescribed this particular medication since at least 01/24/2013. At each subsequent office visit, the employee reports poor sleep quality, high levels of pain, and moderate distress. At each office visit from 05/20/2013 through 09/16/2013, the provider stated upon objective findings that the employee was depressed, in moderate pain, and tearful. There is no documentation of significant improvement in depression or pain level despite the ongoing use of this medication. Satisfactory response to treatment is not indicated, therefore, the ongoing use cannot be determined as medically appropriate. As such, the request is non-certified. **The request for Cymbalta 60MG #30 with two refills is not medically necessary and appropriate.**

#### **4. Methadone 10MG #360 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Section Opioids for Chronic Pain, pg. 80-82, and ACOEM Practice Guidelines, Chapter 3, pg. 47-48, which are part of MTUS, and Official Disability Guidelines, Pain Chapter, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 61-62, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that methadone is recommended as a second line drug for moderate to severe pain if the potential benefits outweigh the risks. Pain relief only last from 4 to 8 hours. As per the clinical notes submitted, the employee has been on the same dose of methadone for a prolonged period of time, and there have been no attempts to titrate down or wean off this medication. The employee continues to report significant pain, poor sleep quality, and no changes to the activity level. Satisfactory response to treatment has not been indicated by a decrease in level of pain, improved function, or improved quality of life. Continuation of this medication cannot be determined as medically appropriate. Therefore, the request is non-certified. **The request for Methadone 10MG #360 is not medically necessary and appropriate.**

#### **5. Dilaudid 8MG #180 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Section, section Opioids for Chronic Pain, pg. 80-82, and ACOEM Practice Guidelines, Chapter 3, pg. 47-48, which are part of MTUS, and Official Disability Guidelines, Pain Chapter, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 74-82, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that short-acting opioids are often used for intermittent or breakthrough pain. The duration of action is generally 3 to 4 hours. A therapeutic trial of opioids should not be employed until the individual has failed a trial of nonopioid analgesics. Baseline pain and functional assessment should be made. The individual should have at least 1 physical and psychosocial assessment by the treating physician to assess whether a trial of opioids should occur. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Based on the clinical information received, the employee has been prescribed Dilaudid 8 mg over a prolonged period of time. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in level of function, or improved quality of life. As per the latest office visit note on 09/16/2013, the employee's pain level remained unchanged, quality of sleep was poor, and activity level remained the same. Objective findings included moderate pain and distress, unsteady gait, restricted range of motion, and tenderness to palpation. The ongoing use of the particular medication cannot be determined as medically appropriate. Therefore, the request is non-certified. **The request for Dilaudid 8MG #180 is not medically necessary and appropriate.**

**6. Lyrica 200MG #90 with two refills is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Section Pregabalin, pg. 99, and section Opioids for chronic pain, pg. 80-82, which are part of MTUS, and ACEOM Guidelines, Chronic Pain Chapter, pg. 110, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 16-20, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that anti-epilepsy drugs are also referred to as anti-convulsants and are recommended for neuropathic pain. Lyrica has been documented to be effective in treatment of diabetic neuropathy and post-herpetic neuralgia. As per the clinical notes submitted for review, the employee's physical examination revealed unsteady gait, joint swelling, restricted range of motion, and tenderness to palpation. The employee has begun the weaning process for Lyrica, and has been tapered from 600 mg to 400 mg per day. Therefore, the medical necessity for 200 mg #90 with 2 refills is not medically appropriate. The MTUS Guidelines state that weaning of Lyrica should occur over a 1 week period. As the employee has already begun the weaning process, the request is non-certified. **The request for Lyrica 200MG #90 with two refills is not medically necessary and appropriate.**

**7. Lexapro 20MG #30 with two refills is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Section tricyclic antidepressants, pg. 13-16, which is part of MTUS, and Official Disability Guidelines, Section Antidepressants, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 13-16, & 107, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for nonneuropathic pain. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessment. Selective serotonin reuptake inhibitors (SSRI) are not recommended as a treatment for chronic pain, it may have a role in treating secondary depression. As per the clinical notes submitted, there is no documentation of a failure to respond to or a contraindication to a tricyclic antidepressant as opposed to an SSRI. There is also no documentation of satisfactory response to treatment including improved pain outcomes, improved function, changes in the use of other analgesic medication, improved sleep quality and duration, or improved psychological symptoms. Therefore, continuation of this medication cannot be determined as medically appropriate, and the request is non-certified. **The request for Lexapro 20MG #30 with two refills is not medically necessary and appropriate.**

**8. Prevacid 30 MG #30 with two refills is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Section Anti-inflammatory medications, pgs. 22, 67-68, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 68-69, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that proton pump inhibitors are recommended for individuals at intermediate of high risk for gastrointestinal events. Individuals with no risk factor and/or no cardiovascular disease, do not require the use of a proton pump inhibitor. Per the clinical notes submitted for review, there is no documentation providing evidence of risk factors or cardiovascular disease that would place this employee at intermediate of high risks for gastrointestinal events. The medical necessity has not been established. Therefore, the request is non-certified. **The request for Prevacid 30 MG #30 with two refills is not medically necessary and appropriate.**

**9. Zolfran 8MG #50 with two refills is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the 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 Physician Reviewer based his/her decision on Official Disability Guidelines (ODG), Chronic Pain Chapter, Online Edition, which is not part of MTUS.

The Physician Reviewer's decision rationale:

The Official Disability Guidelines indicate that Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with the use of opioids. These side effects should tend to diminish over days to weeks of continued exposure. Zofran is FDA (Food and Drug Administration) approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use. Based on the clinical information received, the employee does not currently meet criteria for the use of an antiemetic. As such, the request is non-certified. **The request for Zofran 8MG #50 with two refills is not medically necessary and appropriate.**

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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.

[REDACTED]

CM13-0008481