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**Notice of Independent Medical Review Determination**

Dated: 11/22/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/7/2013  
Date of Injury: 6/5/1989  
IMR Application Received: 7/22/2013  
MAXIMUS Case Number: CM13-0002553

- 1) MAXIMUS Federal Services, Inc. has determined the request for one (1) intrathecal drug delivery system refill between 6/3/13 and 6/3/13 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Wellbutrin 100mg #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm patch 5% #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Desyrel 50mg #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Lyrica 150mg #120 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of opiate medications between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/7/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 one (1) intrathecal drug delivery system refill between 6/3/13 and 6/3/13 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Wellbutrin 100mg #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm patch 5% #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Desyrel 50mg #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Lyrica 150mg #120 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for unknown prescription of opiate medications between 6/3/13 and 8/11/13 **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 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.

### Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 7, 2013:

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#### Clinical Rationale

The patient is a 72 year old male with a date of injury of 6/5/1989. Under consideration is a prospective request for certification of 1 urinalysis drug screen, 1 Intrathecal drug delivery system refill, 30 Wellbutrin 100mg, 30 Lidoderm patch 5%, 90 Colace 100mg, 30 Desyrel 50mg, 3 Fentanyl 100mg, 120 Lyrica 150mg, and an Unknown prescription of opiate medications.

The submitted report on 6/3/2013 by Dr. [REDACTED] indicated the patient complained of low back pain that traveled down both legs. His pain level was unchanged with an average pain level of 4 out of 10 with medications and 9 out of 10 without medications. Relevant objective findings included a slow antalgic walk assisted by the use of a cane. His range of motion of his low back was severely reduced because of pain. His pain increased bending forward and extending back. He had low back tenderness at the L4-S1 level. His sensory and motor examinations showed no change. He was diagnosed with lumbar radiculopathy, lumbar post laminectomy syndrome, cervical radiculopathy, deconditioned state, chronic pain, elevated liver function tests, and status post head trauma w/hearing loss.

#### **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 7/22/13)
- Utilization Review from [REDACTED] (dated 7/07/13)
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records Submitted by Claims Administrator

#### **1) Regarding the request for one (1) intrathecal drug delivery system refill between 6/3/13 and 6/3/13:**

##### Medical Treatment Guideline(s) 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), (section and page not cited), part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Implantable drug-delivery systems (IDDSs), Page 53, part of the MTUS, applicable and relevant to the issue at dispute.

##### Rationale for the Decision:

The employee sustained a work-related injury on June 5, 1989. The medical records provided for review indicate diagnoses include: lumbar radiculopathy, chronic pain, lumbar post laminectomy syndrome, cervical radiculopathy, deconditioned state, elevated liver function tests, and status post head trauma with hearing loss. The records indicate treatments have included the use of a wheelchair and oral analgesic medications. A medical report dated 7/1/13 documents the employee continues to experience low back pain with radiation to the right and left legs, calf and foot. The request is for one (1) intrathecal drug delivery system between 6/3/13 and 6/3/13.

MTUS Chronic Pain Guidelines state the time between refills for an intrathecal (IT) drug pump will vary based on pump reservoir size, drug concentration, dose, and flow rate. The medical records reviewed do not document the employee's reservoir size, the drug concentration, dosage being given, or the specific medication. The records note the employee is receiving 6 mg of the medication per day. Office visits every 2 to 3 weeks for pump refills is not appropriate and not medically indicated. The Official Disability Guidelines state that refill visits are at a minimum of every 4 to 6 weeks, and maximum of every 2–3 months. The

records indicate there have been recent increases in the IT pump opioids, which occurred at successive office visits; however, there are no accompanying physician reports explaining why and what functional expectations were in place. The request for one (1) intrathecal drug delivery system between 6/3/13 and 6/3/13 **is not medically necessary and appropriate.**

**2) Regarding the request for Wellbutrin 100mg #30 between 6/3/13 and 8/11/13:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (current version), Chronic Pain and Mental Illness & Stress, (page note cited) not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Antidepressants for chronic pain, Page 16, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on June 5, 1989. The medical records provided for review indicate diagnoses include: lumbar radiculopathy, chronic pain, lumbar post laminectomy syndrome, cervical radiculopathy, deconditioned state, elevated liver function tests, and status post head trauma with hearing loss. The records indicate treatments have included the use of a wheelchair and oral analgesic medications. A medical report dated 7/1/13 documents the employee continues to experience low back pain with radiation to the right and left legs, calf and foot. The request is for Wellbutrin 100mg #30 between 6/3/13 and 8/11/13.

MTUS Chronic Pain Guidelines indicate that the Wellbutrin is a second generation non-tricyclic antidepressant that is shown to be effective in relieving pain of neuropathic etiologies in small trials, is generally a third-line medication, and may be considered when there is no response to a tricyclic or serotonin–norepinephrine reuptake inhibitor (SNRI). The medical records provided for review do not indicate the employee had been treated for a major depressive disorder, and there is no indication that the employee has failed to respond to a trial of a tricyclic or SNRIs for the treatment of neuropathic pain. The request for Wellbutrin 100mg #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**

**3) Regarding the request for Lidoderm patch 5% #30 between 6/3/13 and 8/11/13:**

Medical Treatment Guideline(s) 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), (section and page not cited), part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the

Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, page 112, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on June 5, 1989. The medical records provided for review indicate diagnoses include: lumbar radiculopathy, chronic pain, lumbar post laminectomy syndrome, cervical radiculopathy, deconditioned state, elevated liver function tests, and status post head trauma with hearing loss. The records indicate treatments have included the use of a wheelchair and oral analgesic medications. A medical report dated 7/1/13 documents the employee continues to experience low back pain with radiation to the right and left legs, calf and foot. The request is for 30 Lidoderm patch 5% between 6/3/13 and 8/11/13.

The MTUS Chronic Pain Guidelines indicate that lidocaine is recommended for neuropathic pain if there is evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an anti-epilepsy drugs (AED) such as gabapentin or Lyrica). The medical records provided for review do not show any findings of neuropathic pain or evidence of a trial of a first-line therapy. The medical records document the employee uses Lyrica, but there is no evidence indicating Lyrica has failed to reduce or alleviate the employee's pain. The request for Lidoderm patch 5% #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**

**4) Regarding the request for Desyrel 50mg #30 between 6/3/13 and 8/11/13:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Mental Illness & Stress, (page note cited), a medical treatment guideline not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the Official Disability Guidelines (ODG), (Online Version), Mental Illness & Stress Chapter, Trazodone (Desyrel), applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on June 5, 1989. The medical records provided for review indicate diagnoses include: lumbar radiculopathy, chronic pain, lumbar post laminectomy syndrome, cervical radiculopathy, deconditioned state, elevated liver function tests, and status post head trauma with hearing loss. The records indicate treatments have included the use of a wheelchair and oral analgesic medications. A medical report dated 7/1/13 documents the employee continues to experience low back pain with radiation to the right and left legs, calf and foot. The request is for Desyrel 50mg #30 between 6/3/13 and 8/11/13.

The Official Disability Guidelines recommend Desyrel for treatment of insomnia for individuals who have also been diagnosed with depression. The medical

records provided for review do not indicate that the employee has insomnia or has been diagnosed with depression. The request for Desyrel 50mg #30 between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**

**5) Regarding the request for Lyrica 150mg #120 between 6/3/13 and 8/11/13:**

Medical Treatment Guideline(s) 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), Anti-epilepsy drugs (AEDs), part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Anti-epilepsy drugs (AEDs), pages 19-20, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on June 5, 1989. The medical records provided for review indicate diagnoses include: lumbar radiculopathy, chronic pain, lumbar post laminectomy syndrome, cervical radiculopathy, deconditioned state, elevated liver function tests, and status post head trauma with hearing loss. The records indicate treatments have included the use of a wheelchair and oral analgesic medications. A medical report dated 7/1/13 documents the employee continues to experience low back pain with radiation to the right and left legs, calf and foot. The request is for 120 Lyrica 150mg between 6/3/13 and 8/11/13.

MTUS Chronic Pain Guidelines recommend the use of anti-epilepsy drugs (AED) such as Lyrica for the treatment of diabetic neuropathy and postherpetic neuralgia and note that this medication also has an anti-anxiety effect. The medical records provided for review do not document that the employee was being treated for diabetic neuropathy and postherpetic neuralgia. The request for 120 Lyrica 150mg between 6/3/13 and 8/11/13 **is not medically necessary and appropriate.**

**6) Regarding the request for unknown prescription of opiate medications between 6/3/13 and 8/11/13:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not provide an evidence basis for their decision. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, (2009), Intrathecal drug delivery systems, medications, pages 54-55, part of the Medical Treatment Utilization Schedule (MTUS), applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on June 5, 1989. The medical records provided for review indicate diagnoses include: lumbar radiculopathy,

chronic pain, lumbar post laminectomy syndrome, cervical radiculopathy, deconditioned state, elevated liver function tests, and status post head trauma with hearing loss. The records indicate treatments have included the use of a wheelchair and oral analgesic medications. A medical report dated 7/1/13 documents the employee continues to experience low back pain with radiation to the right and left legs, calf and foot. The request is for unknown prescription of opiate medications between 6/3/13 and 8/11/13.

MTUS Chronic Pain Guidelines recommend morphine as the initial implantable drug-delivery system (IDDS) medication with a maximum dose of 15mg/day with a concentration of 20mg per ml. The medical records provided for review do not document what opioid is utilized for pump refills or what opioid is being requested. The request for unknown prescription of opiate medications between 6/3/13 and 8/11/13 **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, 18<sup>th</sup> 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.