
Notice of Independent Medical Review Determination

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm Patches **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ambien 10mg **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 8 Aquatic Therapy sessions two (2) times a week for four (4) weeks **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/8/2013 disputing the Utilization Review Denial dated 4/29/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/18/2013. 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 Patches **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ambien 10mg **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 8 Aquatic Therapy sessions two (2) times a week for four (4) weeks **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 April 29, 2013.

“This is a 51-year-old female with a 3/20/2013 date of injury; she was helping close the store and went outside to bring some furniture in. Her manager stopped her and said she shouldn't do it alone. She is now claiming shortness of breath and pain in the mid-back. Employee never moved the furniture from outside the store. She was stopped before she actually moved anything. 4/25/13 progress report indicates continued pain in the right chest and thoracic area. She also complains of bilateral knee pain, left thumb swelling and pain, and radiation of the thoracic pain to the lumbosacral area. Physical exam demonstrates tenderness in the right lateral thoracic area extending to the right subscapular area is minimal edema of the left thumb and thenar eminence with slight tenderness of the first carpometacarpal joint on the left. Treatment to date has included physical therapy, modified duty, and medication. Xrays were negative for a fracture.”

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
- Utilization Review by [REDACTED] (dated 4/29/13)
- Employee's Medical Records by [REDACTED] (dated 3/21/13)
- Primary Treating Physician's Progress Report (dated 4/8/13 thru 6/3/13)
- Work Status Form (dated 4/4/13 thru 6/3/13)
- Employee's Medical Records by [REDACTED] (dated 5/24/13)
- Employee's Medical Records by [REDACTED] (dated 4/12/13 thru 6/7/13)
- Chronic Pain Medical Treatment Guidelines Pg 22, 56-57
- Official Disability Guidelines – Chronic Pain

1) Regarding the request for Lidoderm Patches:

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) – pages 56-57, of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 3/20/13 and experienced bilateral knee pain, left thumb pain and swelling, and chest and thoracic area pain with radiation to the lumbosacral area. Treatment to date has included physical therapy, modified work duty, and medication.

The Chronic Pain Medical Treatment Guidelines indicate Lidoderm is a brand of lidocaine patch. The guidelines state that lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. There is no documentation that the employee has postherpetic neuralgia or has actually failed an adequate length and dosing trial of a first line neuropathic agent. The request for Lidoderm patches is not medically necessary and appropriate.

2) Regarding the request for Ambien 10mg:

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) – Chronic Pain which is 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 guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 3/20/13 and experienced bilateral knee pain, left thumb pain and swelling, and chest and thoracic area pain with radiation to the

lumbosacral area. Treatment to date has included physical therapy, modified work duty, and medication.

Official Disability Guidelines (ODG) - Chronic Pain Chapter, which is not part of the Medical Treatment Utilization Schedule (MTUS). The Guidelines state that Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. A report dated 4/22/13 indicates that Ambien was being prescribed for difficulty sleeping due to pain. Short term use is supported by the ODG guidelines. The request for Ambien 10mg is medically necessary and appropriate.

3) Regarding the request for 8 Aquatic Therapy sessions two (2) times a week for four (4) weeks:

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, page 22, which is 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 guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 3/20/13 and experienced bilateral knee pain, left thumb pain and swelling, and chest and thoracic area pain with radiation to the lumbosacral area. Treatment to date has included physical therapy, modified work duty, and medication.

The Chronic Pain Medical Treatment Guidelines, page 22, states that aquatic therapy is recommended as an alternative to land-based physical therapy. It is specifically recommended where reduced weight bearing is desirable, such as for extremely obese patients. There is no documentation that the employee has a condition related to the reported injury that cannot be addressed on land. The employee does not meet criteria for aquatic therapy. The request for 8 Aquatic Therapy sessions two (2) times a week for four (4) weeks 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/ldh

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.



