

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

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**Notice of Independent Medical Review Determination**

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Dated: **12/23/2013**

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	5/11/2007
IMR Application Received:	8/13/2013
MAXIMUS Case Number:	CM13-0012624

- 1) MAXIMUS Federal Services, Inc. has determined the request for Home care; two hours per day, six days per week for six weeks is not **medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Remeron (mirtazapine 15mg) 1 PO QHS #30 is not **medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/17/2013. 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 Home care; two hours per day, six days per week for six weeks is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for Remeron (mirtazapine 15mg) 1 PO QHS #30 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 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 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 47 year old female who sustained a work related right shoulder injury on 05/11/2007. She underwent right shoulder subacromial decompression, distal clavicle resection, and debridement on 01/03/2013. She also has diagnoses of right extensor and flexor tendonitis, DeQuervain's syndrome, and carpal tunnel syndrome. Per the documentation on exam she has continued right arm pain with decreased range of motion of the right shoulder with palpable spasm. Her treating provider has requested home care: two hours per day, six days per week for six weeks and Remeron as a sleep aid.

### **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:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

- 1) **Regarding the request for Home care; two hours per day, six days per week for six weeks :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the California MTUS Chronic Pain Medical Treatment Guidelines-Home Health Services, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May 2009), pg. 51, which is a part of the MTUS.

Rationale for the Decision:

After a review of the medical documentation provided, it does not indicate that the employee is homebound. Per California MTUS home health services are recommended treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services such as shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. **The request for Home care; two hours per day, six days per week for six weeks is not medically necessary and appropriate.**

- 2) **Regarding the request for Remeron (mirtazapine 15mg) 1 PO QHS #30:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the California MTUS Chronic Pain Medical Treatment Guidelines, page 13-16, Antidepressants for chronic pain, which is a part of the 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 Medscape Internal Medicine: Remeron 2013.

Rationale for the Decision:

Remeron is FDA approved for the treatment of depression and mood disorders. It is a noradrenergic and specific serotonergic antidepressant. It is used off label for the treatment of obsessive compulsive disorder, social anxiety disorder, insomnia, post-traumatic stress disorder, low appetite and nausea. Antidepressants are used for the treatment of chronic neuropathic pain and usually tricyclics are considered first line therapy especially if the pain is accompanied by anxiety, anxiety, or depression. After a review of the medical records provided, there is no documentation provided indicating this employee has a neuropathic pain condition and there are other sleep medications, including over the counter agents such as antihistamines and melatonin, that can be tried as a sleep aid. **The request for Remeron (mirtazapine 15mg) 1 PR QHS #30 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.

[REDACTED]

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