

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/17/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/1/2013
Date of Injury:	1/12/2002
IMR Application Received:	8/26/2013
MAXIMUS Case Number:	CM13-0013377

- 1) MAXIMUS Federal Services, Inc. has determined the request for **functional restoration program quantity 1.00 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Soma 350 mg quantity 90.00 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Ambien 10 mg quantity 30.00 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/26/2013 disputing the Utilization Review Denial dated 8/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **functional restoration program quantity 1.00 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Soma 350 mg quantity 90.00 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Ambien 10 mg quantity 30.00 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 & 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 42-year-old female with reported date of injury on 01/12/2002; the patient was injured while dispensing medications through a cage to an inmate when the inmate reached through the cage and roughly grabbed the patient. The patient had inflammation in the inferior portion of her breasts, increased shoulder, neck, and upper extremity pain. The patient had cervical paraspinal muscle tenderness and bilateral trapezius muscle tenderness, there was tenderness about the insertion of the paraspinal muscles at the occiput and range of motion was restricted. There were mild spasms present. The patient had diagnoses of neck pain status post C5-6 anterior cervical discectomy and fusion (01/08/2009), bilateral wrist pain following carpal tunnel release, and left-sided breast implant dislodgement. The treatment plan included requests for functional restoration program, Soma 350 mg, and Ambien 10 mg.

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:



1) Regarding the request for functional restoration program quantity 1.00 :

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: Functional Restoration Programs, page 49, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Chronic Pain Programs (functional restoration programs), pages 30-33, which is part of MTUS.

Rationale for the Decision:

The employee presented with increased shoulder, neck, and upper extremity complaints status post anterior cervical fusion. The employee stated the pain was mild to moderate and was continuing to utilize a home exercise program. The employee had cervical paraspinal tenderness and bilateral trapezius muscle tenderness, as well as tenderness about the insertion of the paraspinal muscles at the occiput. The employee's range of motion was restricted. The employee previously underwent C5-6 anterior cervical discectomy and fusion on 01/08/2009 and a bilateral wrist carpal tunnel release, as well as corrective surgeries for breast implants related to the injury. The employee had mild spasms present in the cervical spine region. The California MTUS guidelines recommend outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been

addressed. Within the provided documentation, the requesting physician did not provide an adequate and thorough evaluation, including baseline functional testing in order to note functional improvement, previous methods of treating chronic pain were not documented. It was unclear whether the employee had significant loss of ability to function independently resulting from the chronic pain. It was unclear if the employee was a candidate for a surgery or if other treatments would clearly be warranted. The requesting physician did not indicate that the employee exhibited motivation to change and was willing to forego secondary gains, including disability payments to affect this change. Additionally, negative predictors, of success were not addressed within the provided documentation. Further, the requesting physician did not indicate the duration of the program being requested. Therefore, the medical necessity for a functional restoration program cannot be established within the provided documentation.

The request for functional restoration program quantity 1.00 is not medically necessary and appropriate.

2) Regarding the request for Soma 350 mg quantity 90.00:

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, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Muscle Relaxants (for pain), pages 63-66, which is part of MTUS.

Rationale for the Decision:

The California MTUS Guidelines recommend the use of Soma for no longer than a 2 to 3 week period. The guidelines note it is suggested that the medication's main effect is due to generalized sedation, as well as treatment of anxiety. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. According to the provided documentation it appeared the employee was utilizing different forms of muscle relaxants for some time. It was unclear exactly how long the employee was utilizing the specific medication Soma. Prior to Soma, the employee was noted to be utilizing Flexeril since at least 10/08/2012. The guidelines do not recommend long-term use of muscle relaxants; they are recommended for short-term treatment of acute exacerbations in patients with chronic low back pain. Additionally, within the provided documentation it was unclear what first line therapy options the employee tried before muscle relaxants. Therefore, the medical necessity for Soma 350 mg quantity 90 cannot be established. **The request for Soma 350 mg quantity 90.00 is not medically necessary and appropriate.**

3) Regarding the request for Ambien 10 mg quantity 30.00:

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): Ambien, which is not 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): Pain.

Rationale for the Decision:

The Official Disability Guidelines note zolpidem (Ambien) is a prescription short acting non-benzodiazepine hypnotic which is approved for the short term (usually 2 weeks to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual of chronic pain and often is hard to obtain. The guidelines notes sleeping pills can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. Within the provided documentation, the requesting physician did not provide adequate documentation of significant improvement in the employee's sleep pattern with the use of the medication. The efficacy of the medication was unclear within the provided documentation. According to the provided documentation the employee had been utilizing the medication Ambien since at least 10/08/2012. The guidelines do not recommend the long-term use of Ambien. Additionally, the requesting physician did not include adequate documentation of significant sleep disturbances for which the medication was prescribed. Therefore, the medical necessity for Ambien 10 mg quantity 30 cannot be established. **The request for Ambien 10 mg quantity 30.00 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, 18th 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.