

Independent Medical Review Final Determination Letter

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[REDACTED]
[REDACTED]
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Dated: Select Date

IMR Case Number:	CM13-0016097	Date of Injury:	12/13/2004
Claims Number:	[REDACTED]	UR Denial Date:	08/05/2013
Priority:	STANDARD	Application Received:	08/25/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED], MD		
Treatment(s) in Dispute Listed on IMR Application:			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

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 California has a licensed to practice in Internal Medicine. 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:

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

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 claimant is a 37 year old male with a date of injury of 12/13/2004. The diagnosis includes low back pain and he is status post L4-S1 fusion. Objectively, the claimant continues with low back pain with focal tenderness at L4-L5, L5-S1, bilateral superior iliac crests and sacroiliac joints. He has undergone therapy with medical therapy, physical therapy, and trigger point injections.

IMR DECISION(S) AND RATIONALE(S)

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

1. Prescription of Ambien is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS, American College of Occupational and Environmental Medicine (ACEOM), which is part of the MTUS in addition to The Official Disability Guidelines (ODG), Pain (Chronic), which is not part of the MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per 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 Medscape Internal Medicine-Treatment of Insomnia,(2012) which not part of the MTUS.

The Physician Reviewer's decision rationale:

Ambien is a short-acting nonbenzodiazepine hypnotic indicated for the short-term treatment (two to six weeks), for managing insomnia. Long-term use is not recommended as there are associated risks of impaired function and memory with use more than opioids, as well as Ambien may be habit forming. There are no subjective findings of insomnia noted in the medical records submitted dated 7/5/2013. There is documentation in a progress notation from 5/30/2013

indicating the employee was able to sleep the entire night without difficulty. There is no documentation provided indicating medical necessity for Ambien. **The request for Prescription of Ambien is not medically necessary and appropriate.**

2. 1 Weight Loss Program is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS, American College of Occupational and Environmental Medicine (ACEOM), which is part of the MTUS in addition to The Official Disability Guidelines (ODG), Pain (Chronic), which is not part of the MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per 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 Medscape Internal Medicine- Weight Loss Program, (2012), which is not part of MTUS.

The Physician Reviewer's decision rationale:

There is no specific documentation addressed by ACOEM/MTUS Guidelines for weight loss requirements for chronic pain conditions. Per Medscape Internal Medicine weight loss is beneficial for partial relief of symptoms for patients with obesity and arthritis. The provider has not provided a specific goal for weight loss and per the clinical documentation the employee has not undergone any counseling on lifestyle and behavioral modifications, such as diet exercise. The specific weight loss program was not identified. **The request for 1 Weight Loss Program is not medically necessary and appropriate.**

3. Unknown Prescription refill of unknown medication is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS, American College of Occupational and Environmental Medicine (ACEOM), which is part of the MTUS in addition to The Official Disability Guidelines (ODG), Pain (Chronic), which is not part of the MTUS.

The Physician Reviewer was unable to cite and guidelines as the request was not clear.

The Physician Reviewer's decision rationale:

In regard to the request for the unknown medication, with no names, dosages, quantities and frequency of the requested medication, there is no way to determine if the request meets guideline requirements. **The request for Unknown Prescription Refill of Unknown Medication is not medically necessary and appropriate.**

/bd

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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