MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 12/10/2013

Employee:	
Claim Number:	
Date of UR Decision:	8/16/2013
Date of Injury:	5/15/1998
IMR Application Received:	8/28/2013
MAXIMUS Case Number:	CM13-0017516

1) MAXIMUS Federal Services, Inc. has determined the request for **Hydeocodone is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Ambien is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/28/2013 disputing the Utilization Review Denial dated 8/16/2013. 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 **Hydeocodone** is not **medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Ambien is 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 Family Practice , has a subspecialty in ABPM 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:
Male claimant who suffered an injury on 5/15/98 with resultant chronic shoulder and neck pain. He has had chemodenervation of the cervical region on 4/24/13. A PT note on 6-5-13 stated the claimant had difficulty sleeping due to pain and only gets 1 hour of sleep. A prescription by neurology on 8/1/13 was given for hydrocodone, TENS and Ambien. Indications for medications were not provided at the time. A primary care note response to a denial note on 8/26/13 stated that the claimant had failed response to Naprozen, Acetaminophen, Ibuprofen, Celebrex and Gabapentin. An earlier progress note from 1/9/13 states that the claimant was on Vicodin for pain.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for Hydeocodone:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Opiods, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opiods, pages 76, 82-83, which are part of the MTUS.

Rationale for the Decision:
According to the MTUS guidelines cited above, opioids such as hydrocodone are indicated when trials of other non-opioid medication have been not provided improvement. Opioids are also not 1st line therapy for osteoarthritis or neuropathic pain. Although, the provider indicated that the employee had not responded to several other medications, the documentation does not indicate, time used, interval, does escalation or reasons for failure or specific response to the medications. Furthermore, the employee has been intermittently on hydrocodone since Jan 2013 (Vicodin), there is no documentation as to response to Vicodin, timing of use of other alternatives and need for short acting opiods for over past 8 months. **The request for Hydeocodone is not medically necessary and appropriate.**

2) **Regarding the request for Ambien:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Zolpidem (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), Zolpidem (Ambien), which is not part of MTUS.

Rationale for the Decision:
According to the ODG guidelines, Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They 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. In this case, there were numerous times where sleep difficulty was mentioned to the therapist, but no prior note of benzodiazepine. **The request for Ambien is 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.