

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/31/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 08/09/2013
Date of Injury: 09/27/2013
IMR Application Received: 08/29/2013
MAXIMUS Case Number: CM13-0018460

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 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 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 underlying date of injury in this case is over a decade old at 09/27/2003. This patient is a 42-year-old man. His diagnoses include status post C5-C6 discectomy and fusion, status post C6-C7 anterior cervical reconstruction, retained cervical hardware, lumbar discopathy, left shoulder impingement syndrome, status post right shoulder surgery, status post left knee arthroscopy, and right knee pain as a compensatory effect. An initial physician reviewer noted that there had been a treatment plan of 12/14/2014 to discontinue hydrocodone and that there was no indication to retrospectively resume this on 07/10/2013. Therefore, he recommended that that retrospective request be non-certified. The reviewer initially notes that the medical records did not document that the patient had difficulty with sleep and thus he recommended non-certification of a retrospective prescription of 07/10/2013. On 07/10/2013, the patient was seen in followup by the treating physician. Treating physician noted the medication included Motrin three times a day and Anexsia three times a day, Ultram as needed to alleviate pain, Prilosec to protect the stomach, and Ambien to alleviate insomnia, which was helping. The physician stated that the medications were helping the patient to restore functional ability and to help in other activities of daily living. On 06/05/2013, the treating physician indicated that the rationale for Anexsia was to increase the patient's tolerance to other activities in his daily living and to allow him to return to unrestricted full duty.

IMR DECISION(S) AND RATIONALE(S)

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

1. Hydrocodone/APAP 7.5/325mg #120is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Opioids/Ongoing Management, pg. 78, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Medical Treatment Guidelines recommends "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." Prior reviewer notes that the medications do not document the use of hydrocodone. The records do discuss the trade name Anexsia with respect to this medication. That said, the medical records do not clearly discuss functional benefit or the four domains of opioid management, which would particularly be indicated in supporting an indication for this treatment over a decade after the initial injury. Therefore, this request is not certified. **The request for Hydrocodone/APAP 7.5/325mg #120is not medically necessary and appropriate.**

2. Ambien 5mg #30 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of MTUS.

The Physician 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 Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Section Treatment of Workers' Compensation/Pain/Insomnia Treatment, which is not part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS guidelines does not directly discuss this medication. The Official Disability Guidelines recommend that Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). These guidelines do not support an indication for this medication on a chronic basis such as in this case. Prior physician reviewer notes that the medical records do not document the presence of insomnia or sleeping difficulties. The current medical records do include such a discussion. However, it is not clear that the pharmacological treatment of these symptoms with Ambien would be supported by the guidelines. Therefore, this request is not certified. **The request for Ambien 5mg #30is not medically necessary and appropriate.**

/fn

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]

CM13-0018460