

Independent Medical Review Final Determination Letter

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Dated: 12/20/2013

IMR Case Number:	CM13-0018469	Date of Injury:	08/31/1999
Claims Number:	[REDACTED]	UR Denial Date:	08/19/2013
Priority:	STANDARD	Application Received:	08/29/2013
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: PARTIAL OVERTURN. This means we decided that some (but not all) 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]
[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 Psychiatry, 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 patient is a 55 year old female with a date of injury of 8/31/1999. Under consideration are prospective requests for Zoloft, Lunesta and medication management visits. Records submitted for review indicate that the patient is being treated for anxiety and depression with insomnia. Recent examination findings showed her to be stable on her current medication regimen. She has comorbid kidney disease. Her symptoms have included migraine headache. She has been on Lunesta for insomnia since at least 6-5-2013 and her therapy on Lunesta went on for well beyond two months.

IMR DECISION(S) AND RATIONALE(S)

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

1. Zoloft 50mg is medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, SSRIs (selective serotonin reuptake inhibitors), pg. 107, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Because the employee suffers from depression and anxiety, and because pain, depression and anxiety are closely linked and often interwoven, Zoloft is medically necessary, and will be safe and likely helpful for insomnia particularly in the absence of

lunesta or other hypnotics with the potential for producing dependency. **The request for Zoloft 50mg is medically necessary and appropriate.**

2. Lunesta 3mg is not medically necessary and appropriate.

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

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

The Physician Reviewer's decision rationale:

Official Disability Guidelines (ODG) Chronic Pain Chapter, Section on Insomnia Treatment has the following to say about Treatment of Insomnia. Lunesta is part of the non-benzodiazepine category, and this category is recommended for use for four weeks or less. The employee had been on lunesta since at least 6-5-2013 and it is clear from the records provided that treatment with lunesta (eszopiclone) vastly exceeded four weeks. **The request for Lunesta 3mg is not medically necessary and appropriate.**

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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