

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 11/4/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/8/2013
Date of Injury:	7/27/2010
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006247

- 1) MAXIMUS Federal Services, Inc. has determined the request for Mediderm cream 120gm with three refills **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ambien 10mg #30 with three refills **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for one genetic swabbing **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/27/2013. 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 Mediderm cream 120gm with three refills **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ambien 10mg #30 with three refills **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for one genetic swabbing **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 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 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 50 Y, M with a date of injury 2/27/10. The progress report dated 7/1/13 by Dr. [REDACTED], M.D. noted that the patient is diagnosed with traumatic left multi-digit amputation; posttraumatic hypersensitivity; posttraumatic neuropathic pain; stiffness of joint multiple sites; phantom pain, left hand; insomnia. It was noted that the patient reported decreased phantom pain with the Gabapentin at night and the Naproxen and Dendracin lotion decreased pain and helped him use his hand to function and perform ADLs. He was still having a lot of difficulty sleeping. It was noted that on 5/17/13 the patient had a QME evaluation with Dr. [REDACTED] MD who said insomnia is industrial and sedative hypnotics are recommended. The 8/5/13 progress report by Dr. [REDACTED], M.D. noted that the patient reported that the use of the mediderm cream helps him to sleep at night and helped reduce oral intake of medications.

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 Mediderm cream 120gm with three refills:**
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pgs. 111-113, chronic pain section, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee has chronic posttraumatic neuropathic pain and phantom pain of the left hand. The employee reported decreased phantom pain with the Gabapentin at night and the Naproxen and Dendracin lotion decreased pain and gave the employee use his hand to function and perform activities of daily living (ADLs). Dendracin lotion was not approved and so Mediderm cream was prescribed. The 8/5/13 progress report noted that the employee reported that the use of the mediderm cream helps to sleep at night and helped reduce oral intake of medications. The employee clearly has chronic pain in the left upper extremity which has failed conventional therapy. Mediderm cream contains menthol, capsaicin, and methyl salicylate. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case it appears that the guideline criteria for each of the Mediderm ingredients have been met. **The request for Mediderm cream 120gm with three refills is medically necessary and appropriate.**

2) **Regarding the request for Ambien 10mg #30 with three refills:**
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), which is a Medical Treatment Guideline (MTG) that is not part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Pain chapter, Insomnia Treatment, which is a Medical Treatment Guideline (MTG) that is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

On 5/17/13 the employee had a QME evaluation which showed insomnia is industrial and sedative hypnotics are recommended. The progress report dated 7/1/13 noted that the employee was still having a lot of difficulty sleeping, and was prescribed Ambien 10 mg to take as needed. Official Disability Guidelines specify 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. The guideline criteria have been met. **The request for Ambien 10mg #30 with three refills is medically necessary and appropriate.**

3) Regarding the request for one genetic swabbing:
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.

The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), which is a Medical Treatment Guideline (MTG) that is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

Genetic swabbing was done on 7/1/13 and 8/5/13 to test for resistance to meds prescribed. Official Disability Guidelines do not recommend genetic testing for potential opioid abuse. **The request for one genetic swabbing 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

/ldh

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.