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

## Notice of Independent Medical Review Determination

Dated: 11/27/2013

[redacted]

[redacted]

| | |
|---|---|
| Employee: | [redacted] |
| Claim Number: | [redacted] |
| Date of UR Decision: | 7/22/2013 |
| Date of Injury: | 7/3/2007 |
| IMR Application Received: | 8/5/2013 |
| MAXIMUS Case Number: | CM13-0007500 |

1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Ondansetron HCL 4mg #10 is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Ambien 5mg #30 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. 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 retrospective request for **Ondansetron HCL 4mg #10 is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Ambien 5mg #30 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 Oklahoma. 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 40-year-old female who reported an injury on 07/03/2007. The patient was seen by [redacted] on 01/22/2013 with complaints of 6/10 to 8/10 low back pain. It is noted that the patient has been treated with physical therapy, massage, acupuncture, heat packs, ice, TENS unit, and traction. The patient also underwent microlumbar decompression at L4-5 on 06/04/2011. Current medications include gabapentin 10 mg, OxyContin IR 50 mg, Robaxin 750 mg, Promolaxin, and Lyrica 225 mg. Physical examination revealed tenderness to palpation of the lumbar paraspinals, decreased lumbar range of motion, decreased sensation at L4 and L5, and 5/5 strength. Diagnoses included status post lumbar fusion at L5-S1, status post microlumbar decompression at right L4-5, and chronic pain syndrome. Treatment plan at that time included a CT scan of the lumbar spine and continuation of current medications. The patient was again seen by [redacted] on 04/09/2013. The patient continued to complain of 6/10 to 8/10 lower back pain with lower extremity numbness and tingling. Physical examination revealed no significant changes, and treatment plan included a request for spinal cord stimulator trial. The patient was then seen by [redacted] on 04/25/2013. The patient continued to complain of 6/10 to 9/10 low back pain with numbness, burning, tingling, and weakness to bilateral lower extremities. Objective findings revealed no significant changes, and the treatment plan included continuation of current medications and continuation of a home exercise program. An additional followup visit was conducted with [redacted] on 07/09/2013. Patient complaints remained the same, objective findings revealed no significant changes, and the treatment plan included a request for a spinal cord stimulator and a psychological consultation. A Utilization Review Report was submitted on 07/23/2013 by [redacted]. Specific treatments requested included 1 prescription of ondansetron hydrochloride 4 mg #10, 1 prescription of Nucynta ER 50 mg #60, and 1 prescription of Ambien 5 mg #30. The request for

ondansetron hydrochloride 4 mg #10 and Ambien 5 mg #30 were non-certified at that time. The request for Nucynta ER 50 mg #60 was approved. A Functional Capacity Evaluation was completed on 07/25/2013 by [redacted]. It was determined at that time that the patient's overall reports of pain and disability rating findings were consistent, and it was safely concluded that the patient displayed maximum physical effort. The patient did not appear to meet the essential demands of a program supervisor. The patient was then seen by [redacted] on 08/05/2013. The patient presented with continued complaints of 6/10 to 8/10 low back pain. The patient also reported right lower extremity numbness, tingling, and pain to the foot. Objective findings continued to reveal tenderness to palpation of the lumbar paraspinals, decreased sensation to the L4 and L5 dermatomes, and decreased range of motion to the lumbar spine. Treatment plan included continued requests for psychological consultation and spinal cord stimulator trial. A physician progress report was then submitted by [redacted] on 08/14/2013. The patient again reported 8/10 lower back pain with radiation, numbness, tingling, and weakness to bilateral lower extremities. It is noted that the patient has completed 20 visits of physical therapy and 10 to 15 visits of chiropractic treatment. Objective findings included slightly decreased range of motion of the lumbar spine and deceased sensation at L4, L5, and S1 dermatomes on the left side. The patient was given a 30% whole person impairment rating at that time. Current recommendations included a Functional Capacity Evaluation to objectify the patient's complaints and address work restrictions. The patient was also instructed to consult a podiatrist and continue pain management followups. An additional progress report was submitted by [redacted] on 08/27/2013. The patient at that time complained of 4/10 right knee pain. Objective findings included negative McMurray's, negative anterior and posterior drawer, 0 to 130 degree range of motion, and positive painful patellofemoral crepitus with motion. The patient was given a 2% whole person impairment rating at that time. Future medical treatment included anti-inflammatory and analgesic medication, as well as possible intra-articular corticosteroid and viscosupplemental injections.

**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 retrospective request for Ondansetron HCL 4mg #10:**

   <u>Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision</u>
   The Claims Administrator based its decision on the Official Disability Guidelines (OGD), Chronic Pain Chapter, Online Version, which is not a 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), Chronic Pain Chapter, Ondansetron (Zofran), which is not part of the MTUS.

Rationale for the Decision:
Official Disability Guidelines state that ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Anti-emetics are only recommended for acute use. Nausea and vomiting is common with the use of opioids. Ondansetron is a 5-HT3 receptor antagonist, which is approved for nausea and vomiting secondary to chemotherapy and radiation treatment, as well as postoperative use. Acute use is FDA approved for gastroenteritis. As per the clinical notes submitted, there is no indication that this employee suffers from a diagnosis of gastroenteritis, nor is there indication that this employee is utilizing this medication secondary to chemotherapy and radiation treatments. **The retrospective request for Ondansetron HCL 4mg #10 is not medically necessary and appropriate.**

2) **Regarding the retrospective request for Ambien 5mg #30:**

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 (OGD), Online Version, which is not a 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), Chronic Pain Chapter, Zolpidem (Ambien), which is not part of the MTUS.

Rationale for the Decision:
Official Disability Guidelines state that zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term treatment of insomnia. Cognitive behavioral therapy should be an important part of an insomnia treatment plan. There is no documentation submitted for this review that provides evidence of this employee's failure of non-prescription hypnotic medication for the treatment of insomnia. There is also no documentation providing evidence of this employee's active participation in cognitive behavioral therapy as part of an insomnia treatment plan. There is also no evidence provided of this employee's failure to respond to non-pharmacological treatment for insomnia, including proper sleep hygiene techniques. Guidelines only recommend prescription zolpidem for 2 to 6 weeks short-term treatment **The retrospective request for Ambien 5mg #30 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

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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.