

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

3400

[Redacted]

Dated: 12/30/2013

IMR Case Number:	CM13-0029382	Date of Injury:	03/22/2004
Claims Number:	[Redacted]	UR Denial Date:	09/20/2013
Priority:	STANDARD	Application Received:	09/27/2013
Employee Name:	[Redacted]		
Provider Name:	[Redacted]		
Treatment(s) in Dispute Listed on IMR Application:			
PLEASE SEE PAGE 2			

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 Occupational Medicine, 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic neck pain reportedly associated with an industrial injury of March 22, 2004.

Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; muscle relaxant; topical agents; unspecified number of epidural steroid injections; prior surgical fusion surgery at C5 through C7; and extensive periods of time off of work.

A utilization review report of September 24, 2013, the claims administrator denied request for Ambien, Soma, and topical Lidoderm patches. The applicant's attorney later appealed.

An earlier note of September 16, 2013 is notable for comments that the applicant reports persistent neck pain with neuropathic pain in the neck region. The applicant is also having disrupted sleep. It is stated that the applicant is getting improved pain and function. The applicant's pain level with medications is 2/10 and 6/10 without medications. The applicant states that ongoing medication usage is resulting in improved function. The applicant is on Ambien, Soma, Norco, Lidoderm, and oxycodone. He is obese with a BMI of 34. He is presently off of work and unemployed, it is stated. Decreased cervical range of motion and associated tenderness were noted. The applicant is issued refills of oxycodone, Lidoderm, Norco, Ambien, and Soma.

IMR DECISION(S) AND RATIONALE(S)

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

1. Ambien CR 12.5mg #30 with 1 refill is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the 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 Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Low Back Chapter, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS does not specifically address the topic. As noted in the ODG Chronic Pain chapter, Zolpidem topic, Zolpidem or Ambien is only recommended for short-term (two to six weeks) usage for insomnia purposes. It is not recommended in the chronic, long-term, scheduled once nightly context present here, particularly in conjunction with numerous other opioids and non-opioid medications. Therefore, the original utilization review decision is upheld. The request remains non-certified, on independent medical review.

2. Carisoprodol 350mg #120 with 1 refill is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma), page 29, which is part of the MTUS.

The Physician Reviewer's decision rationale:

As noted on page 29 of the MTUS Chronic Pain Medical Treatment Guidelines, Soma is not indicated for long-term use, particularly in conjunction with other analgesics. In this case, the applicant is using numerous other opioid and non-opioid medications. Addition of Soma to the same is noted to augment the effect of other drugs and sometimes generates euphoria. Continued usage of Soma in this context is not indicated, particularly in light of all the other opioids and non-opioid medications the applicant is using. Therefore, the request remains non-certified, on independent medical review.

3. Lidocaine 5% #4 is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Lidocaine, page 112, which is part of the MTUS.

The Physician Reviewer's decision rationale:

As noted on page 112, the MTUS Chronic Pain Medical Treatment Guidelines, topical Lidoderm or lidocaine patches are recommended as a third line option in the treatment of neuropathic pain in those individuals in whom first line antidepressants and/or anticonvulsants have tried and/or failed. In this case, however, there is no clear evidence or description of the failure of antidepressant and/or anticonvulsant medications so as to make the case for usage of topical Lidoderm. Accordingly, the request remains non-certified, on independent medical review.

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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