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## Independent Medical Review Final Determination Letter

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Dated: 12/27/2013

<b>IMR Case Number:</b>	CM13-0018008	<b>Date of Injury:</b>	6/18/2013
<b>Claims Number:</b>	██████████	<b>UR Denial Date:</b>	8/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	8/29/2013
<b>Employee Name:</b>	██████████		
<b>Provider Name:</b>	██████████ MD		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>	Norco 5/325 #100x3; Ambien CR 12.5 #30x3		

DEAR ██████████

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, ██████████

## 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 06/18/2013. The current treating diagnosis is a shoulder/arm sprain.

A prior physician review recommended a non-certification of Norco with the rationale that there was no documentation of subjective or objective benefit from this medication. Ambien was noncertified in that review given the lack of indication for ongoing or chronic use of this medication.

### IMR DECISION(S) AND RATIONALE(S)

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

**1. Norco 5/325 #100 times three is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 78, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines Section of Opioids/Ongoing Management, page 78, recommends "Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects...Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids." The medical records contain very limited information regarding these 4 domains for criteria for monitoring opioid use. The records do not support an indication for this treatment based on the guidelines. This request is not medically necessary.

**2. Ambien CR 12.5 #30 times three is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines.

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Pain, Insomnia.

The Physician Reviewer's decision rationale:

The California guidelines do not directly address the use of Ambien. The Official Disability Guidelines/Treatment in Workers' Compensation/Pain under Insomnia Treatment states, "Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance...Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days)." The medical records do not provide a rationale for the use of Ambien in contrast to the guidelines, particularly for a prolonged period of time. This treatment is not medically necessary.

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]

CM13-0018008