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

Notice of Independent Medical Review Determination

Dated: 10/2/2013

[redacted]

Employee:	[redacted]
Claim Number:	
Date of UR Decision:	7/9/2013
Date of Injury:	4/16/2004
IMR Application Received:	7/18/2013
MAXIMUS Case Number:	CM13-0001957

1) MAXIMUS Federal Services, Inc. has determined the request for additional acupuncture 12 visits for the cervical, thoracic and lumbar spine **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for Aciphex **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for Ambien **is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for Flector patches **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/22/2013. 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 additional acupuncture 12 visits for the cervical, thoracic and lumbar spine **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for Aciphex **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for Ambien **is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for Flector patches **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 Preventive Medicine and 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 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.

Case Summary:
Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013:

"Review of the medical documentation identifies the claimant sustained an industrial injury on 04/16/04. The claimant has been under the care of the attending provider for rotator cuff, localized primary osteoarthritis of the leg, cervical disc degeneration, and chronic pain. The most recent evaluation dated 06/10/13 is provided for review. The claimant presented with complaints of neck and low back pain rated at 8/10 with continued bilateral upper extremity weakness and pain. Objective findings reveal decreased cervical and lumbar range of motion. Motor exam is 5-/5 for bilateral quadriceps and hamstrings, 4+/5 for bilateral tibialis anterior, EHL, Inversion, and eversion. This is limited by pain."

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 for Independent Medical review (received 07/18/2013)
- Utilization Review Determination from [redacted] (dated 07/09/2013)
- Employee Medical Records provided by Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for additional acupuncture 12 visits for the cervical, thoracic and lumbar spine :**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:
The Claims Administrator based its decision on the Acupuncture Medical Treatment Guidelines which are part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:
The employee sustained a work-related injury on April 16, 2004 to the neck and back. The medical records provided for review indicate treatments have included physical therapy, aqua therapy, acupuncture, and medication management. The request is for additional acupuncture, 12 visits for the cervical, thoracic, and lumbar spine.

The Acupuncture Medical Treatment Guidelines suggest that acupuncture treatment's efficacy is observed when there is a measured functional improvement, and/or dependency on continued medical treatment. However, the medical records provided for review do not document evidence of the employee's functional status improvement in relation to prior acupuncture treatment. The request for additional acupuncture, 12 visits for the cervical, thoracic, and lumbar spine **is not medically necessary and appropriate**.

2) **Regarding the request for prescription Aciphex:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:
The Claims Administrator did not cite any evidence-based guidelines for its decision on any cited guidelines. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 68, which is part of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:
The employee sustained a work-related injury on April 16, 2004 to the neck and back. The medical records provided for review indicate treatments have included

physical therapy, aqua therapy, acupuncture, and medication management. The request is for prescription Aciphex.

The MTUS Chronic Pain Medical Treatment Guidelines recommend treatment with a proton-pump inhibitor (PPI) for active gastrointestinal (GI) symptoms, or NSAIDs related GI events. The medical records reviewed lack the documentation of the employee taking NSAIDs or exhibiting any active GI symptoms. The treatment objective of medication use was not specified; no applicable diagnosis was documented. The request for Aciphex **is not medically necessary and appropriate.**

3) **Regarding the request for prescription Ambien** :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:
The Claims Administrator based its decision on the Official Disability Guidelines (ODG) Integrated Treatment/ Disability Duration Guidelines, Stress & Mental Illness Chapter (2008) which is a medical treatment guideline that is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated the MTUS does not address the issue in dispute. The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Chronic Pain Chapter, Zolpidem section, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:
The employee sustained a work-related injury on April 16, 2004 to the neck and back. The medical records provided for review indicate treatments have included physical therapy, aqua therapy, acupuncture, and medication management. The request is for prescription Ambien.

The Official Disability Guidelines recommend a 6-week maximum for Ambien use for insomnia. Ambien is indicated for the short-term treatment of insomnia characterized by difficulties with sleep initiation. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. The medical records submitted for review indicate the employee was prescribed Ambien, but they do not describe insomnia or any problems with sleeping, daytime drowsiness, or impairment from lack of restful sleep. The request for Ambien **is not medically necessary and appropriate.**

4) **Regarding the request for Flector patches:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:
The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Pain Chapter, Topical analgesics, which is a medical treatment guideline that is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment

Guidelines (May, 2009) pg. 111, which is part of the MTUS and relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:
The employee sustained a work-related injury on April 16, 2004 to the neck and back. The medical records provided for review indicate treatments have included physical therapy, aqua therapy, acupuncture, and medication management. The request is for Flector patches.

The MTUS Chronic Pain Medical Treatment guidelines indicate Flector patch for the topical treatment of acute pain due to minor strains, sprains, and contusions. The medical records reviewed do not describe acute inflammatory signs, the indication for prescribing this medication was unspecified, and the records did not describe a medical necessity for this medication. The condition at issue is chronic, so any pain relief treatment should be derived from the chronic pain treatment plan, and a broad chronic pain treatment plan in which this medication played a part was undocumented in the records reviewed. The request for Flector patches **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

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.