

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/19/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/18/2013
Date of Injury: 1/20/2005
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0006629

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 Family Practice 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 employee is a 61-year-old male who reported an injury on 01/20/2005 while working as a truck driver delivering a load of sugar. He reported he felt pain in his lower back. A clinical note dated 05/07/2013, signed by Dr. [REDACTED] reported the employee complained of ongoing, aching, heavy, and throbbing pain in his lower back, which he rates 3/10 at that time. He reported his worst pain over the past week was 7/10 and when he was not taking his medications was 6/10. When he was taking his medications it was 2/10. He reported his low back and leg pain were about 50/50 respectively. The employee also reported difficulties with activities of daily living. The employee is noted to have undergone 2 previous lumbar fusions in 2005 and in 2012. He is reported to complain of poor sleep quality, muscle cramps, and back pain. The employee complained of heartburn and indigestion. The employee is noted to have limited range of motion on physical examination, muscle spasms, and mild tenderness along the bilateral lumbar spine. Positive facet loading maneuvers for pain at L4-5 and L5-S1, trace weakness on knee extension, ankle dorsiflexion, and EHL on the right side and left side. Trace diminished reflex of the bilateral medial hamstrings and at the bilateral Achilles tendon. The employee is noted to continue to treatment with Dr. [REDACTED] and continued to have complaints of ongoing low back pain, noting when he does not take medications, his pain is 6/10 and after taking medication, his pain was 2/10.

IMR DECISION(S) AND RATIONALE(S)

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

1. Omeprazole DR 20 mg #30 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, page 69, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, page 69, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that proton pump inhibitors, such as omeprazole are recommended for employees with complaints of gastrointestinal events secondary to non-steroidal anti-inflammatory drugs (NSAIDs). The guidelines also indicate that the treatment for dyspepsia secondary to NSAID therapy includes stopping the NSAID, switching to a different NSAID, or considering an H2 receptor antagonist or PPI. According to the medical records provided for review, the employee is noted to report complaints of heartburn and indigestion and is reported to be taking Relafen; however, there is no indication this is related to the non-steroidal anti-inflammatories. **The request for Omeprazole DR 20 mg #30 is not medically necessary and appropriate.**

2. Relafen 750 mg #60 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs (non-steroidal anti-inflammatory drugs), pages 22, 67-68, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs (non-steroidal anti-inflammatory drugs), pages 67-68, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain and they are also recommended as an option for short-term symptomatic relief for chronic low back pain. According to the medical records provided for review, the employee appears to be taking the Relafen on an ongoing, routine basis. The requested Relafen does not meet guideline recommendations. **The request for Relafen 750 mg #60 is not medically necessary and appropriate.**

3. Zolpidem Tartrate 10 mg #30 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Pain (Chronic), Chapter, which is not 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 Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Pain (Chronic), Chapter, Zolpidem (Ambien).

The Physician Reviewer's decision rationale:

The ODG Guidelines indicate that the use of zolpidem is recommended for short term treatment of insomnia, usually only 2 to 6 weeks. According to the medical records provided for review, the employee appears to have been taking the zolpidem on a routine, long-term basis. The requested for zolpidem does not meet guideline recommendations. **The request for Zolpidem Tartrate 10 mg #30 is not medically necessary and appropriate.**

/mg

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.

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[REDACTED]
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