

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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**Notice of Independent Medical Review Determination.
Case Number CM13-000054**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the physical therapy three (3) times a week for four (4) weeks requested **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the Soma refill requested **is not medically necessary or appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the Lyrica refill requested **is not medically necessary or appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the Norco refill requested **is not medically necessary or appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on March 12, 2013 disputing the Utilization Review Denial dated March 5, 2013. A Notice of Assignment and Request for Information was provided to the above parties on April 23, 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 physical therapy three (3) times a week for four (4) weeks requested is medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the Soma refill requested is not medically necessary or appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the Lyrica refill requested is not medically necessary and appropriate.
- 4) MAXIMUS Federal Services, Inc. has determined the Norco refill requested is not medically necessary and appropriate.

Medical Qualifications of the Professional 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, has a subspecialty certificate in Pain Medicine and is licensed to practice in Maryland. 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 professional 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 March 5, 2013.

“Initial evaluation was done on 12/28/12. The patient reports neck pain that radiates into the right arm as well as numbness of the elbow and right thumb. He reports symptoms for the last three weeks with worsening of symptoms the past week. Medications are noted as Lyrica, Soma and Norco. Examination notes tenderness over the trapezius musculature and interscapular region. Pain is noted at the extremes of motion to the cervical spine. Muscle power is noted as normal to the upper extremities. There is hypesthesia of the right thumb and hyperesthesia of right arm down to elbow. X-rays of cervical spine were reported to show restricted cervical lordosis secondary to spasm and narrowing and degenerative changes to C5-6 disc space. The most recent

note dated 02/13/13 notes the patient has returned to work and has had a cervical epidural injection with temporary relief of symptoms. He has had an ergonomic workstation evaluation and changes are in process. He was seen due to complaints of electric shock going from right shoulder to below his elbow. Examination notes good range of motion to the cervical spine with pain at the extremes. Medications were refilled and physical therapy is recommended. Consideration for a second epidural injection. An MRI from 12/30/12 showed mild spinal stenosis at C4-5 and C5-6, moderate bilateral neural foraminal narrowing at C4-5 due to unvertebral joint proliferation and unvertebral joint proliferation at C5-6 with a right 0.3 cm paracentral and possible foraminal protrusion associated with osteophyte formation. There is severe left and moderate right neural foraminal narrowing at C5-6 level.

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:

- IMR Application
- Utilization Review - [REDACTED] dated 3/5/13)
- Medical Records from [REDACTED] (dated 12/28/12 – 2/12/13)
- MRI Cervical Spine w/o Contrast - [REDACTED] (dated 12/30/12)

1) Regarding the Request for physical therapy three (3) times a week for four (4) weeks:

Medical Treatment Guideline(s) Relied Upon by the Professional Reviewer to Make His/Her Decision: The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Addition, (2004) and Official Disability Guidelines (ODG) (2009). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision: Physical therapy is an established treatment for cervical pain and associated radiculopathy. The employee’s physical exam, medical history and magnetic resonance imaging (MRI) findings support the diagnosis and treatment plan. The requested physical therapy visits are medically necessary and appropriate.

2) Regarding the Request for Soma refill:

Medical Treatment Guideline(s) Relied Upon by the Professional Reviewer to Make His/Her Decision: The Claims Administrator based its decision on the

ACOEM Guidelines and Chronic Pain Medical Treatment Guidelines (2009). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision: The employee's physical exam, medical history and MRI findings support the diagnosis. Long-term use of muscle relaxants is not well-established by the treatment guidelines above. The requested Soma refill is not medically necessary or appropriate.

3) Regarding the Request for Lyrica refill:

Medical Treatment Guideline(s) Relied Upon by the Professional Reviewer to Make His/Her Decision: The Claims Administrator based its decision on the ACOEM Guidelines and Chronic Pain Medical Treatment Guidelines (2009). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision: The employee's physical exam, medical history and MRI findings support the diagnosis. Long-term use of opioids is not well-established by the treatment guidelines above. The requested Lyrica refill is not medically necessary or appropriate.

4) Regarding the Request for Norco refill:

Medical Treatment Guideline(s) Relied Upon by the Professional Reviewer to Make His/Her Decision: The Claims Administrator based its decision on the ACOEM Guidelines and Chronic Pain Medical Treatment Guidelines (2009). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision: ACOEM Guidelines do not support the treatment request. The requested Norco refill is not medically necessary or 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

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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.