

## Notice of Independent Medical Review Determination

Dated: 12/2/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/22/2013  
Date of Injury: 4/4/2010  
IMR Application Received: 8/13/2013  
MAXIMUS Case Number: CM13-0012900

- 1) MAXIMUS Federal Services, Inc. has determined the request for **12 sessions of hand therapy for the left wrist is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **unknown quantity of Zanaflex is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **initial interdisciplinary HELP evaluation is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/19/2013. 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 **12 sessions of hand therapy for the left wrist is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **unknown quantity of Zanaflex is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **initial interdisciplinary HELP evaluation is 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 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.

### Expert Reviewer Case Summary:

The applicant is a represented 24-year-old [REDACTED] who has filed a claim for chronic left wrist pain reportedly associated with an industrial injury of April 4, 2010.

Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; trigger point injections; a TENS unit; unspecified amounts of chiropractic manipulative therapy; transfer of care to and from various providers in various specialties; unspecified amount of physical therapy over the life of the claim; a left wrist ORIF surgery; and extensive periods of time off of work. In a July 21, 2013, utilization review report, the claims administrator partially certified four sessions of hand therapy, partially certified as 90 tablets of Zanaflex.

In a letter of July 18, 2013, the applicant's primary treating provider states that the applicant has sought authorization for multidisciplinary evaluation as a precursor to functional restoration program, citing the applicant's issues with sleep disturbance, weight gain, pain, and deconditioning. It is stated that the applicant is motivated to return to school and, ultimately, to gainful employment. The applicant has a history of panic attacks.

A July 2, 2013 consultation is notable for comments that the applicant is not working and is using Norco, Valium, and Soma. It is stated that the applicant should try and streamline the medication profile, stop Soma, and start Zanaflex

**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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for 12 sessions of hand therapy for the left wrist:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS. The Claims Administrator also cited the Official Disability Guidelines, physical/occupational therapy, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, physical medicine, pages 98-99, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines endorse active therapy, active modalities, hand therapy, and self-directed home physical medicine. The guidelines also endorse tying extension of treatment to some demonstration of functional improvement. In this case, however, the employee has failed to effect or demonstrate any functional improvement to date. The fact that the employee off of work, several years removed from the date of injury, continues to use several analgesic and adjuvant medications shows lack of functional improvement with prior physical therapy. Since a functional restoration program precursor evaluation is being requested, there is an indication that lower levels of care, such as physical therapy, have been tried and failed. **The request for twelve (12) sessions of hand therapy for the left wrist is not medically necessary and appropriate.**

**2) Regarding the request for unknown quantity of Zanaflex :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, muscle relaxants (for pain), pages 63 and 66, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate tizanidine or Zanaflex is FDA approved in the management of spasticity, and that it is supported on a short-term basis for unlabelled purposes in the management of low back pain. The guidelines also indicate that this medication is not recommended on a long-term basis. In this case, however, the bulk of the applicant's symptoms seemingly pertain to the wrist as opposed to the spine, although it is incidentally noted that there do appear to be some ancillary complaints of neck and low back pain. The attending provider has not clearly stated prescription frequency, prescription duration, or prescription amount for Zanaflex. **The request for an unknown quantity of Zanaflex is not medically necessary and appropriate.**

**3) Regarding the request for initial interdisciplinary HELP evaluation :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Chronic pain programs (functional restoration programs), page 32, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that a precursor evaluation is generally endorsed prior to consideration of a multidisciplinary pain management program. In this case, the attending provider has suggested that the employee has tried and failed numerous other alternate options, including physical therapy, home exercises, a TENS unit, surgery, medications, etc. The attending provider has stated the employee is motivated to change, is motivated to return to work and/or return to school. Providing a precursor evaluation to determine fitness and suitability for interdisciplinary pain management program is indicated in this context. **The request for an initial interdisciplinary HELP evaluation is 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,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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