

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/2/2013
Date of Injury: 9/8/2005
IMR Application Received: 8/16/2013
MAXIMUS Case Number: CM13-0013517

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 Physical Medicine and Rehabilitation, and is licensed to practice in New York and Texas. 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 patient is a 54-year-old male with a reported date of injury of 09/08/2005. The claimant is known to have neck pain radiation to the bilateral upper extremities and low back pain radiating to the bilateral lower extremities with associated numbness and tingling. Notes indicate that medications help decrease pain and inflammation and allow the patient to perform ADLs. On examination, the patient has decreased range of motion of the cervical and lumbosacral spine with spasms. The claimant has decreased sensation in the bilateral upper as well as decreased motor strength. The patient has diagnosis of cerebral concussion with headaches, amnesia, neurological deficits, myofascial laceration, cervical strain, cervical disc herniation with radiculopathy, left shoulder impingement syndrome. The claimant has been recommended for medication management and acupuncture. The claimant has undergone prior urine drug screens.

IMR DECISION(S) AND RATIONALE(S)

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

1. Acupuncture, two (2) times a week for five (5) weeks to the cervical spine is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Acupuncture Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines state that "acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery." CA MTUS guidelines also state that 3 to 6 sessions to produce effect. The documentation submitted for review indicates that the patient does have

pain in the neck and low back radiating to the extremities. However, the proposed therapy is not being used as an adjunct to physical therapy and/or surgical intervention. Furthermore, the request for 10 sessions of treatment would exceed California MTUS Guidelines for initial duration of care. .

2. Acupuncture two (2) times a week for five (5) weeks to the left shoulder is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Acupuncture Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines state that "acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery." CA MTUS guidelines also state that 3 to 6 sessions are recommended to produce effect. The documentation submitted for review indicates that the employee does have pain in the neck and low back radiating to the extremities. However, the proposed therapy is not being used as an adjunct to physical therapy and/or surgical intervention. Furthermore, the request for 10 sessions of treatment would exceed California MTUS Guidelines for initial duration of care.

3. Zanaflex, 4mg, #60 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Tizanidine, pgs. 63-66, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines state that tizanidine (Zanaflex) is FDA approved for management of spasticity and can be use off label for low back pain. CA MTUS guidelines also state muscle relaxants are recommend as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The documentation submitted for review does indicate that the employee has muscle spasms and tenderness. However, the employee has been using Zanaflex long-term. As to the above, California MTUS Guidelines only recommend short-term use of Zanaflex.

4. Norco is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, and pgs. 76-78, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines state that "The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the

"4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." The documentation submitted for review does indicate the employee has cervical and lumbar spine pain radiating to the extremities. However, the employee's pain has not been rated on a VAS scale in recent notes. It is reported that the employee's medications decreased pain and inflammation which allowed the employee to do ADLs. However, there are no specifics regarding the percentage of pain relief. As such, the request is non-certified at this time given the lack of documentation of the 4A's.

5. Remeron 15mg, #30 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antidepressants, pg. 13, which is part of the MTUS

The Physician Reviewer's decision rationale:

CA MTUS guidelines state that Remeron, antidepressants, for chronic pain are "recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain." CA MTUS guidelines also state long-term effectiveness of anti-depressants has not been established. The documentation submitted for review indicates the employee has been utilizing Remeron long-term. California Guidelines do not recommend the long-term use of antidepressants. Furthermore, the available records do not provide specifics with regards to the effectiveness of medication regimen as symptoms were not rated on a VAS scale.

6. Ambien 10mg, #30 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert 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 Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG) Pain Chapter.

The Physician Reviewer's decision rationale:

CA MTUS and ACOEM guidelines do not address Ambien. However, Official Disability Guidelines states that Zolpidem (Ambien) "is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia." The documentation submitted for review fails to provide subjective complaints of insomnia with description of symptoms. Furthermore, the employee has been utilizing Ambien for greater than 6 weeks. As guidelines only recommend Ambien for insomnia up to 6 weeks, the request is not consistent with Official Disability Guidelines.

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]
[REDACTED]
[REDACTED]

CM13-0013517