

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

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



---

**Notice of Independent Medical Review Determination**

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/30/2013
Date of Injury:	1/29/2011
IMR Application Received:	8/20/2013
MAXIMUS Case Number:	CM13-0014197

- 1) MAXIMUS Federal Services, Inc. has determined the request for **purchase of compressive lumbar support brace is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **purchase of lumbar support cushion for driving is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Tizanidine 1 #90 is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Acetaminophen 500 mg #120 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/20/2013 disputing the Utilization Review Denial dated 7/30/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/3/2013. 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 **purchase of compressive lumbar support brace is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **purchase of lumbar support cushion for driving is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Tizanidine 1 #90 is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Acetaminophen 500 mg #120 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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:**

This is a male patient with the date of injury of January 29, 2011. A utilization review determination dated July 30, 2013 recommends non-certification for compressive lumbar support brace and lumbar support cushion for driving, Tizanidine, and acetaminophen. A progress report dated July 18, 2013 identifies that the employee is a 39-year-old man who has been employed as a bus driver by the [REDACTED] since March 2010. On January 7, 2011, he was working in his usual customary duties when he developed low back pain, which he believes was a result of his seat "bottoming out" repeatedly. Initially, his pain was primarily in his low back. The note goes on to identify that he was "treated conservatively with physical therapy and medications with limited improvement." Subjective complaints include "pulling, stretching, and tight sensation. There's also intermittent radiation to the left lower extremity, which may last for several minutes at a time, and often improves with changing position. He rates the pain 4-6 on a scale of 1 to 10 most of the time, currently 6, and up to 7 at times, usually in the morning upon awakening." Physical examination identifies reduced range of motion and lumbar spine as well as tenderness to palpation around the lumbosacral area. Spasm is also identified in the lumbosacral spine. Diagnoses include low back pain, multilevel

degenerative disc disease, and mild left-sided radiculopathy. Current recommendations include etodolac and "recently with Tylenol #3." Recommendations go on to say "we have provided prescriptions for a non-narcotic analgesic and a nonsteroidal anti-inflammatory, as indicated in the California MTUS and ACOEM, and an anti-spasmodic."

**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 Treatment Utilization Schedule (MTUS)
- Medical Records from:
  - Claims Administrator
  - Employee/Employee Representative
  - Provider

**1) Regarding the request for purchase of compressive lumbar support brace:**

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 CA MTUS 2009 ACOEM, which is part of the MTUS, and the ODG, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12) pages 300-301, which is part of the MTUS, and the Official Disability Guidelines Low Back Chapter, which is not part of the MTUS.

Rationale for the Decision:

Regarding the request for compressive lumbar support brace, ACOEM Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Official Disability Guidelines (ODG) state that lumbar supports are not recommended for prevention. They go on to state that lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. Within the medical records provided for review, it does not appear that this employee had any acute or subacute phase of treatment. The employee's date of injury is January 29, 2011. ACOEM guidelines clearly recommend against lumbar supports beyond the acute phase. ODG recommend lumbar supports during the subacute phase only. **The request for purchase of compressive lumbar support brace is not medically necessary and appropriate.**

## 2) Regarding the request for purchase of lumbar support cushion for driving:

### 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 CA MTUS 2009 ACOEM, which is part of the MTUS, and the ODG, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12) pages 300-301, which is part of the MTUS, and the Official Disability Guidelines Low Back Chapter, which is not part of the MTUS.

### Rationale for the Decision:

Regarding the request for lumbar support cushion for driving, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Official Disability Guidelines (ODG) state that lumbar supports are not recommended for prevention. They go on to state that lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. Within the medical records provided for review, it does not appear that this patient had any acute or subacute phase of treatment. The employee's date of injury is January 29, 2011. ACOEM guidelines clearly recommend against lumbar supports beyond the acute phase. ODG recommends lumbar supports during the subacute phase only. **The request for lumbar support cushion for driving is not medically necessary and appropriate.**

## 3) Regarding the request for Tizanidine 1 #90 :

### 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 CA MTUS 2009 Chronic Pain Treatment Guidelines, which is part of the MTUS.

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

### Rationale for the Decision:

Regarding the request for Tizanidine, MTUS Chronic Pain Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbation in patients with chronic low back pain. With regards to Tizanidine specifically, guidelines state that it is FDA approved for the management of spasticity and unlabeled for use for low back pain. Within the medical records provided for review, the requesting physician has identified that the employee has muscle spasms present on physical examination as well as flare-ups of pain which occur intermittently. Additionally, the employee has tried other first line medications previously. **The request for Tizanidine 1 #90 is medically necessary and appropriate.**

**4) Regarding the request for Acetaminophen 500 mg #120:**

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 CA MTUS 2009 Chronic Pain Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines page 12, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines recommend acetaminophen for treatment of chronic pain and acute exacerbation of chronic pain. However, the records provided for review indicate that the employee is currently taking Tylenol #3. It is unclear what dose of Tylenol #3 the employee is currently using, and what dose of acetaminophen is currently being prescribed. The concurrent use of two sources of acetaminophen significantly increases the risk of acetaminophen overdose and potential hepatotoxicity. **The request for Acetaminophen 500mg #120 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,

Paul Manchester, MD, MPH  
Medical Director

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

/MCC

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.