

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: 12/31/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/19/2013
Date of Injury: 5/18/2010
IMR Application Received: 8/22/2013
MAXIMUS Case Number: CM13-0014704

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: PARTIAL OVERTURN. This means we decided that some (but not all) 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 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 underlying date of injury in this case is 5/18/2010. This patient is a 56-year-old woman. Her diagnoses include lumbar spine disc syndrome, thoracic sprain, lumbar facet syndrome, lumbar radiculopathy, lumbar disc syndrome, NSAID induced gastropathy, and facet arthropathy. The patient has been noted to have ongoing low back pain with numbness and tingling, though primarily nonradiating pain. The patient reported only brief improvement from epidural steroid injection. The patient's medications include Tizanidine and hydrocodone. The patient has been noted to have an antalgic gait. An initial physician reviewer recommended noncertification of a cool and hot contrast system, indicating there was no evidence in the guidelines to support such a device. Tizanidine was noncertified with the rationale it is a muscle relaxant not indicated for long-term use. Urine drug testing was noncertified given that past testing results were not included.

IMR DECISION(S) AND RATIONALE(S)

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

1. ThermoCool hot & cold unit is not medically necessary and appropriate.

The Claims Administrator based its decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 308-310, which is part of MTUS.

The Physician Reviewer based his/her decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3), pg. 48, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM Guidelines indicate that during the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for

temporary amelioration of symptoms to facilitate mobilization and graded exercise. The guidelines, therefore, do not support the use of durable medical equipment for thermal modalities in the current chronic phase. The records provided for review do not provide an alternate rationale for this request. **The request for thermoCool hot & cold unit is not medically necessary and appropriate.**

2. Tizanidine 4 mg #30 is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 66, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Drug Testing, pg. 43, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Medical Treatment Guidelines indicate that Tizanidine unlabelled use for back pain. One study demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. The prior reviewer stated that this medication is not approved for recommendation for chronic use. The MTUS guidelines, however, do encourage this medication for chronic use, particularly in complex situations as this, with both neuropathic and myofascial pain and an uncertain benefit from opioid medications or a desire to use less opiate medications. The guidelines do support this request for Tizanidine. This treatment is reasonable and necessary. **The request for Tizanidine 4 mg #30 is medically necessary and appropriate.**

3. UDT (Urine drug testing) is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, section Opioids, pg. 77-80, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Muscle Relaxants, pg. 63, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Medical Treatment Guidelines recommended urine drug testing as an option to assess for the use or presence of illegal drugs. The prior review indicated that this testing was not indicated given the lack of discussion of past results. Certainly past results would place the results in context, particularly when interpreting these results. However, particularly for an employee on chronic opioid medications without certain clinical benefit, the guidelines would support random drug testing. This request is certified. **The request for UDT (Urine drug testing) is medically necessary and appropriate.**

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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.

[REDACTED]

[REDACTED]

[REDACTED]