

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: **12/12/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/8/2013
Date of Injury:	7/25/2005
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0019508

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Metaxalone, 800mg, #90 between 7/22/2013 and 10/5/2013 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 8/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **Metaxalone, 800mg, #90 between 7/22/2013 and 10/5/2013** 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 Family 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:**

This injured worker's date of injury was 7/25/2013. She has persisting L shoulder pain that is now chronic. The symptoms include muscle spasms. She has a prior history of bilateral shoulder impingement syndrome, adhesive capsulitis, myofascial pain, and neuropathic pain. She has had surgery- left shoulder subacromial decompression in October 2005. There are notes from her rehabilitation center, but the legibility of the description of the physical exams are poor. On 8/29/2013 she had a left shoulder arthroscopic debridement of the anterior superior labral tear and rotator cuff tear repair of the glenohumoral joint.

### **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 Metaxalone, 800mg, #90 between 7/22/2013 and 10/5/2013:**

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.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 63-65.

Rationale for the Decision:

This employee has chronic pain. Metaxalone is a muscle relaxer. The guidelines indicate, in general, that muscle relaxers are indicated as a second-line treatment for the short-term management of musculoskeletal pain due to spasm. It is not a drug of choice in patients with chronic pain. Its efficacy diminishes over time. Sedation is a common side effect. Prolonged use of this drug may create dependency. **The request for Metaxalone, 800mg, #90 between 7/22/2013 and 10/5/2013 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

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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.