
Notice of Independent Medical Review Determination

Dated: 9/26/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/2/2013

10/12/2011

7/11/2013

CM13-0001185

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for synovacin glucosamine sulfate 500mg #90 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for Tizanidine 4mg #90 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request Topiramate 100mg #60 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/11/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/12/2013. 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 retrospective request for synovacin glucosamine sulfate 500mg #90 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for Tizanidine 4mg #90 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request Topiramate 100mg #60 **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 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013:

“The patient is a 37-year-old male with a date of injury of 10/12/2011. The provider has submitted authorization requests for one prescription of ketoprofen 75mg #60, one prescription of synovacin glucosamine sulfate 500mg #90, one prescription of tizanidine 4mg #90 and one prescription of Topiramate 100mg #60. Review of documentation dated 6/19/2013 by [REDACTED], PA-C noted that the patient reported right upper back tingling and numbness with right upper extremity tingling and numbness, as well as low back pain that was mild to moderate. Objectively, he presented with tenderness to palpation”

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 for Independent Medical Review (received 7/11/13)
- Utilization Review Determination (dated 7/3/13)
- Employee medical records from Dr. [REDACTED] (dated 5/31/12)
- Employee medical records from [REDACTED] (dated 6/25/12-6/19/13)
- Employee medical records from [REDACTED] (dated 4/23/13-5/21/13)
- Employee medical records from [REDACTED] (dated 6/29/12)

- Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 16-22, 63-73

1) Regarding the retrospective request for synovacin glucosamine sulfate 500mg #90:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based guidelines its decision. The provider did not dispute the lack of guidelines by the Claims Administrator. The Expert Reviewer cited Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 50, which is a part of the Medical Treatment Utilization Schedule (MTUS), as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 10/12/11 and has experienced pain in the lower and upper back, spine, legs and left shoulder with tingling and numbness reported. The medical records provided for review indicate that the employee has had chiropractic treatment for his spine pain and prescribed medications that include trazodone, omeprazole, synovacin, topiramate and Flexeril. The retrospective request was submitted for synovacin glucosamine sulfate 500mg#90.

The MTUS Chronic Pain guidelines do not recommend the use of glucosamine for chronic pain, however It does recommend its use in the treatment of moderate osteoarthritis. The medical records provided for review do not document that the patient has a diagnosis of osteoarthritis in his major joints. The retrospective request for synovacin glucosamine sulfate 500mg#90 **is not medically necessary or appropriate.**

2) Regarding the retrospective request for Tizanidine 4mg #90:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009) pg. 66 which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 10/12/11 and has experienced pain in the lower and upper back, spine, legs and left shoulder with tingling and numbness reported. The medical records provided for review indicate that the employee has had chiropractic treatment for his spine pain and prescribed medications that include trazodone, omeprazole, synovacin, topiramate and Flexeril. The retrospective request was submitted for tizanidine 4mg #90.

The MTUS Chronic Pain guidelines states that muscle relaxants may be used for exacerbations of acute chronic low back pain for short periods in the treatment of

tension and pain. The medical records provided for review do not document objective signs of spasm nor is there is documentation of how the patient previously reacted to muscle relaxants. Moreover, the records provided for review indicate that the patient has mild to moderate back pain. The retrospective request for tizanidine 4mg #90 **is not medically necessary or appropriate.**

3) Regarding the retrospective request for Topiramate 100mg #60:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009) pg. 16-17 which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 10/12/11 and has experienced pain in the lower and upper back, spine, legs and left shoulder with tingling and numbness reported. The medical records provided for review indicate that the employee has had chiropractic treatment for his spine pain and prescribed medications that include trazodone, omeprazole, synovacin, topiramate and Flexeril. The retrospective request was submitted for topiramate 100mg #60.

The MTUS Chronic Pain guidelines state that topiramate should have at least a 30%-50% response in decreasing pain. The medical records provided for review do not document this effect. The retrospective request for topiramate 100mg #60 **is not medically necessary or 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

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

/th

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.