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**Notice of Independent Medical Review Determination**

Dated: 10/15/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/9/2013  
Date of Injury: 1/11/2009  
IMR Application Received: 7/15/2013  
MAXIMUS Case Number: CM13-0001616

- 1) MAXIMUS Federal Services, Inc. has determined the request for Tramadol ER 150 mg #60 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ketoprofen 75mg #90 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 4mg #90 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg #30 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for chiropractic/physiotherapy treatment 2 times a week for 4 weeks for the lumbar spine **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/15/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/18/2013. 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 Tramadol ER 150 mg #60 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ketoprofen 75mg #90 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 4mg #90 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg #30 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for chiropractic/physiotherapy treatment 2 times a week for 4 weeks for the lumbar spine **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 9, 2013:

“As per the referral, this 56 year old female has a date of injury of 1111109. AME dated 5/14/12 notes the claimant with complaints of pain in the neck, left shoulder, and low back with radiation to the lower extremities despite physical therapy, epidural steroid injection, and medications MRI of the lumbar spine dated 4/25109 revealed L4-S facet arthropathy resulting in mild canal stenosis and bilateral L5 spondylosis with a grade I anterolisthesis and broad based disc bulge at L5-S1 resulting in severe bilateral neuroforaminal narrowing. On 9115109, the claimant had a spinal stimulator Implantation to the lower back which decreased the pain. Exam. showed cervical spine flexion to 45 degrees, extension to 46 degrees, right lateral bending to 32 degrees, left lateral bending to 31 degrees, right/left lateral rotation to 67 degrees, the lumbar spine showed-discomfort with deep palpation about the paraspinal region on the left, flexion to 16 degrees, extension to 12 degrees, right lateral bending to 10 degrees, left lateral bending to 12 degrees, antalgic gait, a positive straight leg raise bilaterally, and decreased sensation involving the

left medial leg and left 1st and 2nd toes. X-rays of the lumbar spine I revealed changes consistent with the laminectomy at L5-S1 with posterior spinal fusion and pedicle screw instrumentation are again noted posteriorly for the Grade II spondylolisthesis. The plan is for a diagnostic plan for lumbar discography. Office visit dated 6/21/13 notes the claimant with complaints of pain in the low back that radiates down to the lower extremities despite physical therapy, epidural steroid injection, and medications. Exam showed tenderness to palpation over the stimulator site; range of motion is decreased in all planes, and decreased sensation left L4, L5, and S1 dermatomes. The diagnoses are status post revision and fusion at L5-S1 on 8/21/12, lumbar radiculopathy, retained bone stimulator, and status post left ankle fracture. The plan is for a bone stimulator removal, medication refills, and physical therapy.

### **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 7/15/13)
- Utilization Review Determination (dated 7/9/13)
- Employee medical records from [REDACTED] (dated 7/11/12-6/12/13)
- Employee medical records from [REDACTED] MD (dated 7/16/12-10/12/12)
- Employee medical records from [REDACTED] (dated 8/6/12)
- Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 12, 55-66, 68-69, 74-96, 111-112

### **1) Regarding the request for Error! Reference source not found.**

#### 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 (2009), pg. 80 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 based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pg. 94-95, which is part of the MTUS as relevant and appropriate for the employee's clinical circumstance

#### Rationale for the Decision:

The employee sustained a work-related injury to the left ankle and low back on 1/11/09. The medical records provided for review indicate treatment has included: analgesic medications; adjuvant medication; lumbar fusion surgery with subsequent revision; chiropractic care, home exercise and work restrictions. The medical report of 6/12/13 reports pain levels of 3-5/10, recent training on home exercises, and also states ongoing usage of current medications continue to decrease pain and normalize function. The request is for Tramadol ER 150mg.

The MTUS Chronic Pain guidelines recommend frequent review of medication and careful documentation in order to avoid misuse and/or addiction. The medical records reviewed document that Norco and Gabapentin continue to decrease pain and normalize functioning, and there is no documentation of

previous use of Tramadol. The request for Tramadol ER 150mg #60 is not medically necessary and appropriate.

**2) Regarding the request for Ketoprofen 75mg #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, (2009) pg. 72, 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 based his/her decision on The Chronic Pain Medical Treatment Guidelines (2009), pg. 72, which is part of the MTUS, as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury to the left ankle and low back on 1/11/09. The medical records provided for review indicate treatment has included: analgesic medications; adjuvant medication; lumbar fusion surgery with subsequent revision; chiropractic care, home exercise and work restrictions. The medical report of 6/12/13 reports pain levels of 3-5/10, recent training on home exercises, and also states ongoing usage of current medications continue to decrease pain and normalize function. The request is for Ketoprofen 75mg #90.

MTUS Chronic Pain guidelines state that ketoprofen or Orudis is indicated in the treatment of mild-to-moderate pain such as that associated with arthritis and other painful conditions. The medical records reviewed document mild-to-moderate, 3-5/10 pain levels which would meet guideline criteria for ketoprofen. The request for Ketoprofen 75mg #90 is medically necessary and appropriate.

**3) Regarding the 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 (2009), pg 63, 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 based his/her decision on The Chronic Pain Medical Treatment Guidelines (2009), pg. 72, which is part of the MTUS, as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury to the left ankle and low back on 1/11/09. The medical records provided for review indicate treatment has included: analgesic medications; adjuvant medication; lumbar fusion surgery with subsequent revision; chiropractic care, home exercise and work restrictions. The medical report of 6/12/13 reports pain levels of 3-5/10, recent training on home exercises, and also states ongoing usage of current medications continue to decrease pain and normalize function. The request is for Tizanidine 4 mg #90.

The MTUS Chronic Pain guidelines endorse Tizanidine as an FDA approved anti-spasticity drug and it has an off-label use for treatment of lower back pain.

The medical records provided for review indicate that the focus was on ankle pain and lower extremity pain, not lower back pain, and there is no documentation of tizanidine usage. The request for Tizanidine 4 mg #90 is not medically necessary and appropriate.

#### **4) Regarding the request for Omeprazole 20mg #30**

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 (2009), pg. 68-69, which is a 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 sustained a work-related injury to the left ankle and low back on 1/11/09. The medical records provided for review indicate treatment has included: analgesic medications; adjuvant medication; lumbar fusion surgery with subsequent revision; chiropractic care, home exercise and work restrictions. The medical report of 6/12/13 reports pain levels of 3-5/10, recent training on home exercises, and also states ongoing usage of current medications continue to decrease pain and normalize function. The request is for Omeprazole 20mg # 30.

The MTUS Chronic Pain guidelines recommend a proton pump inhibitor in the treatment of NSAID-induced dyspepsia. The medical records provided for review fail to document the presence of any signs or symptoms of reflux, dyspepsia, and/or heartburn, either stand-alone or as a result of NSAID usage. The request for Omeprazole 20mg #30 is not medically necessary and appropriate.

#### **5) Regarding the request for the chiropractic/physiotherapy treatment 2 times a week for 4 weeks for the lumbar spine**

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 (2009) pg. 68-69, which is a 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 sustained a work-related injury to the left ankle and low back on 1/11/09. The medical records provided for review indicate treatment has included: analgesic medications; adjuvant medication; lumbar fusion surgery with subsequent revision; chiropractic care, home exercise and work restrictions. The

medical report of 6/12/13 reports pain levels of 3-5/10, recent training on home exercises, and also states ongoing usage of current medications continue to decrease pain and normalize function. The request is for chiropractic-physiotherapy treatment 2 times per week for 4 weeks.

While the MTUS Chronic Pain Medical Treatment Guidelines do tepidly endorse usage of chiropractic manipulative therapy or manual therapy in the treatment of various chronic pain conditions, the Chronic Pain Guidelines do endorse tying extension of treatment to clear evidence of functional improvement and evidence of successful return to work. The records reviewed In this case document no clear evidence that the employee has returned to work; there is no evidence of functional improved as defined in the MTUS 9792.20f. The employee has failed to improve in terms of functional status, work restrictions, and/or improved performance of activities of daily living, and/or reduction in dependence on medical treatment; work status is seemingly unchanged. The request for multiple medications and multiple treatments, such as manipulative therapy, suggest that there is no reduction in dependence on medical treatment. The request for Chiropractic/Physiotherapy treatment 2 times per week for 4 weeks 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;

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