

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/31/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/11/2013
Date of Injury: 12/19/2007
IMR Application Received: 7/17/2013
MAXIMUS Case Number: CM13-0001796

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: UPHOLD. This means we decided that none 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 12/19/2007. This patient is a 65-year-old woman. The patient's diagnoses include cervicothoracic strain, bilateral knee pain with posttraumatic patellar syndrome, bilateral rotator cuff tendinitis, bilateral elbow tendinitis, right hip myalgia parasthetica, and healed right 8th rib fracture. An initial physician review noted that there was no documentation of the medical necessity for a beta blocker since there was no diagnosis of elevated blood pressure or other cardiac conditions. Additionally, the reviewer noted that there was no subjective assessment to support the anti-anxiety medication diazepam and there is no documentation of a gastrointestinal condition to support an indication for omeprazole. This reviewer noted that the guidelines allow for a trial of massage and noted the patient had documentation of back pain and that massage to the shoulders and back therefore should be certified to permit 4 sessions. The reviewer noted that there was not documentation of an objective exam documenting point tenderness in the sacroiliac region and that therefore a right sacroiliac injection would be noncertified.

IMR DECISION(S) AND RATIONALE(S)

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

1. Inderal 20 mg #90 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the California Medical Treatment Utilization Schedule (MTUS).

The Physician Reviewer's decision rationale:

The MTUS Guidelines indicate that the Federal Drug Administration (FDA) approved labeling information for Inderal states that indications include “hypertension, angina pectoris due to coronary atherosclerosis, migraine prophylaxis, or hypertrophic subaortic stenosis.” The medical records provided for review do not indicate any of these diagnoses nor an alternative rationale for this medication. **The request for Inderal 20 mg #90 is not medically necessary and appropriate.**

2. Diazepam 5 mg #120 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, pages 24 and 66, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, page 24, which is part of the MTUS.

The Physician Reviewer’s decision rationale:

The Chronic Pain Guidelines indicate that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. The guidelines also indicate that chronic benzodiazepine use is the treatment of choice in very few conditions. The medical records provided for review do not indicate an alternate rationale to support an indication for gastrointestinal prophylaxis. **The request for Diazepam 5 mg #120 is not medically necessary and appropriate.**

3. Omeprazole 20 mg #30 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, page 68, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, page 68, which is part of the MTUS.

The Physician Reviewer’s decision rationale:

The Chronic Pain Guidelines indicate, “Determine if the patient has a risk for gastrointestinal events: age greater than 65 years, history of peptic ulcer or GI bleeding, concurrent use of ASA, corticosteroids, or high dose/multiple anti-inflammatory medications.” The medical records provided for review do not clearly document these or other indications for gastrointestinal prophylaxis. **The request for Omeprazole 20 mg #30 is not medically necessary and appropriate.**

4. Four (4) sessions of massage therapy to bilateral shoulders and back is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Massage therapy, page 60, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Massage therapy, page 60, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that massage therapy should be an adjunct to other recommended treatment, for example, exercise and it should be limited to 4-6 visits in most cases. The guidelines do not indicate that massage is always indicated in a case of back pain. Rather, massage may be indicated when it is specifically a short-term adjunct to facilitate a longer term treatment, most notably longer term active exercise. The medical records provided for review do not indicate at this time that massage has been proposed as an adjunct to other treatment. It is not clear how this treatment would provide meaningful benefit in this chronic phase beyond very short-term improvement. **The request for four (4) sessions of massage therapy to bilateral shoulders and back is not medically necessary and appropriate.**

5. One (1) right sacroiliac (SI) joint injection is not medically necessary and appropriate.

The Claims Administrator based its decision on the Work Loss Data Institute, ODG Treatment in Workers' Compensation, 5th Edition, 2007 or current year, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 800, which is part of the MTUS. The Physician Reviewer also cited the Official Disability Guidelines (ODG), Treatment in Workers' Compensation/hip/sacroiliac blocks, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM Guidelines indicate, "Invasive techniques e.g. local injections are of questionable merit." The Official Disability Guidelines indicate, "Diagnostic evaluation must first address any other possible pain generators...the history and physical should suggest the diagnosis." The medical records provided for review indicate multiple pain generators; however, it is not clear from the history or physical exam findings that the employee meets criteria to diagnose focal sacroiliac pain. **The request for one (1) right sacroiliac (SI) joint injection is not 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]

CM13-0001796