
Notice of Independent Medical Review Determination

Dated: 10/16/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/8/2013
Date of Injury:	12/13/2011
IMR Application Received:	7/22/2013
MAXIMUS Case Number:	CM13-0002557

- 1) MAXIMUS Federal Services, Inc. has determined the request for tizanidine **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for milnacipran (Savella) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for additional physical therapy six (6) times **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 tizanidine **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for milnacipran (Savella) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for additional physical therapy (6) six times **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 Preventive Medicine and Occupational Medicine 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 8, 2013:

"Patient presents with hand and wrist pain. States no new injuries or events since last being seen. Additional OT denied, she is trying to do HEP. She also completed PT. A request to return to Doctor to see if there is any orthopedic explanation for her lack of progress. States she is losing grip strength in the hand. She is to have AME with Dr. [REDACTED]. She has completed three sessions of acupuncture with functional permanent being able to [blank], such ADLs as emptying the dishwasher total, whereas before acupuncture she could only empty one third of the dishwasher before taking a break, this is using both hands. She is also beginning to use her right hand to turn the key while starting the car before she was using her left hand. She decreased her Vicodin use with acupuncture to about once a month. Patient continues to remain off work she cannot get her modified work met. She notes benefit from Galise and tizanidine. Patient reports constant aching, throbbing pain over this thenar aspect of the right hand and lateral aspect of right forearm, and on volar aspect of forearm. Pain extends up to shoulder and axilla. The hand feels cold and burning during the day. States she still has problems with extension, but can do torquing motions such as opening a lock, which she could not do before. States she is concerned about getting bumped in the crowd. Pain rated at 7/10 and made worse by writing, twisting of right wrist, lifting, pushing, and pulling and made better by rest. Patient states there has been continuing pain disproportionate to the inciting event. States upper extremity has been sensitive to

normally non-painful stimuli, has felt cold or that there have been changes in skin color, there is been edema but not sweating changes, and there is been ridging of right thumbnail. ADLs reviewed."

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 7/22/13)
- Utilization Review Determination from [REDACTED] (dated 7/8/13)
- Employee Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for tizanidine:

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), Antispasticity/Antispasmodic Drugs, Tizanidine, page 66, which is part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found the guidelines used by the Claims Administrator and additionally, found the MTUS §9792.20(f) was relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on December 13, 2011 to the right thumb and right hand. The medical records provided for review indicate treatments have included: analgesic medications, adjuvant medications, right trigger thumb release surgery, right tenosynovitis of radial styloid release surgery in 2012, analgesic medications, adjuvant medications, stellate ganglion blocks, topical agents, unspecified amounts of acupuncture, unspecified amounts of occupational therapy, and extensive periods of time off of work. The medical report of June 26, 2013 documents that the employee is losing grip strength in the hand, is taking tizanidine for pain relief, the employee reports that the overall pain is 7/10, and there is 4/5 right wrist strength with 5/5 left wrist strength. The request is for tizanidine.

The MTUS Chronic Pain Guidelines indicate tizanidine is FDA approved in the management of spasticity and often prescribed off label for low back pain. The medical records provided for review do not show evidence that the employee has issues with spasticity or low back pain, and there is no evidence of functional improvement following completion of the use of tizanidine. Tizanidine is not indicated in the context of the employee's chronic regional pain syndrome and/or chronic upper extremity pain. The request for tizanidine **is not medically necessary and appropriate.**

2) Regarding the request for milnacipran (Savella):

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

The Claims Administrator based its decision on the National Library of Medicine, Medline Plus, a nationally-recognized professional standard, which is not part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. 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 on December 13, 2011 to the right thumb and right hand. The medical records provided for review indicate treatments have included: analgesic medications, adjuvant medications, right trigger thumb release surgery, right tenosynovitis of radial styloid release surgery in 2012, analgesic medications, adjuvant medications, stellate ganglion blocks, topical agents, unspecified amounts of acupuncture, unspecified amounts of occupational therapy, and extensive periods of time off of work. The medical report of June 26, 2013 documents that the employee is losing grip strength in the hand, is taking tizanidine for pain relief, the employee reports that the overall pain is 7/10, and there is 4/5 right wrist strength with 5/5 left wrist strength. The request is for milnacipran (Savella).

The National Library of Medicine, Medline Plus indicates that Savella is recommended for the treatment of fibromyalgia. The medical records provided for review does not show evidence of a diagnosis of fibromyalgia, or indicate the reason for the use of this medication. The request for milnacipran (Savella) **is not medically necessary and appropriate.**

3) Regarding the request for additional physical therapy (6) six times:

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), Manual Therapy and Manipulation, pages 58-59, which is part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, pages 8 and 99, part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on December 13, 2011 to the right thumb and right hand. The medical records provided for review indicate treatments have included: analgesic medications, adjuvant medications, right trigger thumb release surgery, right tenosynovitis of radial styloid release surgery in 2012, analgesic medications, adjuvant medications, stellate ganglion blocks, topical agents, unspecified amounts of acupuncture, unspecified amounts of occupational therapy, and extensive periods of time off of work. The medical report of June 26, 2013 documents that the employee is losing grip strength in the hand, is taking tizanidine for pain relief, the employee reports that the overall

pain is 7/10, and there is 4/5 right wrist strength with 5/5 left wrist strength. The request is for additional physical therapy six (6) times.

The MTUS Chronic Pain Guidelines recommends up to 24 sessions of treatment for the diagnosis of chronic regional pain syndrome, and suggests that there should be demonstration of functional improvement at different achievements to show the need for continued treatment. The medical records provided for review indicate that there is no evidence of functional improvement with prior occupational therapy, and the employee remains off of work. The request for additional physical therapy six (6) times **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, 18th Floor
Oakland, CA 94612

/sh

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.