

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/22/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/15/2013  
Date of Injury: 6/5/2007  
IMR Application Received: 7/24/2013  
MAXIMUS Case Number: CM13-0003044

- 1) MAXIMUS Federal Services, Inc. has determined the request for Amitiza 24mcg QTY: 60.00 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 4mg QTY: 180.00 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Voltaren Gel 1% 4 grams QTY: 1.00 **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 Amitiza 24mcg QTY: 60.00 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 4mg QTY: 180.00 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Voltaren Gel 1% 4 grams QTY: 1.00 **is not medically necessary and appropriate.**

### Medical Qualifications of the Expert Reviewer:

The 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 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 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 15, 2013:

"██████████ is a 54 year old (DOB: ██████████) male worker. The mechanism of injury is not noted. The date of injury was on 6/05/2007. He sustained injury to his Right Shoulder, Soft Tissue-Neck.. His current work status is not noted. The Right Shoulder, Soft Tissue-Neck has been accepted by the Carrier."

### 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 (date 8/14/2013)
- Utilization Review Determination from ██████████ (date 7/15/2013)
- Medical Records from ██████████ (date 8/1/2013)
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request Amitiza 24mcg QTY: 60.00:**

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

The Claims Administrator offered no evidenced-based guidelines with which to base its decision. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Therapeutic Trial of Opioids, page 77, part of the MTUS relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured in an industrially related accident on 6/05/2007. The submitted and reviewed medical records indicate that the employee sustained an injury to the right shoulder and neck. The records indicate that the employee has had surgery to the neck and right rotator cuff as well as medication therapy. The progress report, dated 7/01/2013, indicated that the employee was experiencing intermittent stabbing and tingling in the neck and right shoulder. A request was submitted for Amitiza 24mcg # 60, Tizanidine 4mg # 180, and Voltaren Gel 1% 4 grams # 1.

MTUS Chronic pain Guidelines note that prophylactic treatment of constipation should be initiated when initiating opioid therapy. The reviewed medical records indicate that the employee is also taking Percocet for chronic pain. The employee takes the Amitiza 24 mcg for constipation. The request for Amitiza 24mcg # 60 **is medically necessary and appropriate.**

2) **Regarding the request for Tizanidine 4mg QTY: 180.00:**

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, no page cited, part of the MTUS. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Antispasticity/Antispasmodic Drugs, page 66, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured in an industrially related accident on 6/05/2007. The submitted and reviewed medical records indicate that the employee sustained an injury to the right shoulder and neck. The records indicate that the employee has had surgery to the neck and right rotator cuff as well as medication therapy. The progress report, dated 7/01/2013, indicated that the employee was experiencing intermittent stabbing and tingling in the neck and right shoulder. A request was submitted for Amitiza 24mcg # 60, Tizanidine 4mg # 180, and Voltaren Gel 1% 4 grams # 1.

MTUS Chronic pain Guidelines state that Tizanidine is recommended for use as a first line option to treat myofascial pain. The progress report dated 7/1/13 notes that the employee complained of intermittent stabbing and tingling pain in the neck that radiates to the right shoulder. The employee takes the Tizanidine 4 mg

½-1 po bid-tid prn for myofascial pain. The request for Tizanidine 4mg # 180 **is medically necessary and appropriate.**

3) **Regarding the request** Voltaren Gel 1% 4 grams QTY: 1.00:

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, pages 111-113, part of the MTUS. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-113, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured in an industrially related accident on 6/05/2007. The submitted and reviewed medical records indicate that the employee sustained an injury to the right shoulder and neck. The records indicate that the employee has had surgery to the neck and right rotator cuff as well as medication therapy. The progress report, dated 7/01/2013, indicated that the employee was experiencing intermittent stabbing and tingling in the neck and right shoulder. A request was submitted for Amitiza 24mcg # 60, Tizanidine 4mg # 180, and Voltaren Gel 1% 4 grams # 1.

MTUS Chronic pain Guidelines, state that Voltaren 1% gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. The records indicate the employee was complaining of neck and right shoulder pain. The request for Voltaren gel 1% 4 grams # 1 **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.