
Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

IMR Case Number:	CM13-0003499	Date of Injury:	11/19/2004
Claims Number:	██████████	UR Denial Date:	07/10/2013
Priority:	Standard	Application Received:	07/26/2013
Employee Name:	██████████		
Provider Name:	██████████, MD		
Treatment(s) in Dispute Listed on IMR Application:	1 prescription of Tizanidine-Zanaflex HCL 4mg, #90, 1 prescription of Pantoprazole 20mg, #30ms, #90, 1 prescription of Trazodone 50mg, #90ms, #90, 1 prescription of Hydrocodone/bit/apap 5/35mg, #30ms, #30, and 1 prescription of Sentra PM medical food, #60		

DEAR ██████████

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: PARTIAL OVERTURN. This means we decided that some (but not all) 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, ██████████

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 Anesthesiology, has a subspecialty in Pain 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 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:

45 y/o injured worker male with injury date of 11/19/2004. His case was evaluated by UR on 7/9/2013, and the most recent provider note evaluated for the UR determination was 7/3/13. Dr. [REDACTED] wrote a response to the UR on 7/19/13. Injured worker has had lumbar surgery, acupuncture, TENS unit, spinal cord stimulation, physical therapy, and medication trials to treat back and leg pain.

IMR DECISION(S) AND RATIONALE(S)

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

1. One (1) prescription of Tizanidine-Zanaflex HCL 4mg, #90 is medically necessary and appropriate.

The Claims Administrator based its decision on Chronic Pain Medical Treatment Guidelines (2009), Tizanidine, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guideline Tizanadine pg. 66, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The UR physician cites the MTUS regarding muscle relaxants in general when referring to the recommendation that these agents should be used for short durations. However, the MTUS comments specifically on this agent, and states: "Tizanidine (Zanaflex®, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant

decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002)”

The provider in his response to the UR determination clarified that this medication is used prn for acute spasms and has documented muscle spasms periodically in the records. The 7/3/13 note documents treatment plan for muscle spasms.

No specific functional benefit is described in the records (there is documentation of subjective improvement) but such documentation is not required by the MTUS.

2. One (1) prescription of Pantoprazole 20mg, #30ms, #90 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, GI and Cardiovascular risk, which is part of the MTUS.

The Physician Reviewer’s decision rationale:

At the time of the UR determination, there was no documentation of peptic ulcer disease for which injured worker takes Pantoprazole. This was elucidated later in the reply to the UR physician, however at the time of the determination there was not documentation supporting the medical necessity of pantoprazole.

3. One (1) prescription of Trazodone 50mg, #90ms, #90 is medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Pain (Chronic), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG) Insomnia, which is not part of the MTUS.

The Physician Reviewer’s decision rationale:

The UR physician states that in their review of the records, they find no documentation of insomnia or depression. In the provider’s reply to the UR determination, provider clarifies that the injured worker has had depression and insomnia. In addition many provider notes document the use of this medication for these purposes. I respectfully disagree with the UR physician that this was not documented before. ODG advocates for use of trazodone for insomnia with depression. 2009 MTUS p13 is silent on trazodone in particular, but notes antidepressants for pain are “Recommended as a first line option...for non-neuropathic pain.”

ODG states “Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Improvements in sleep onset may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation.”

4. 1 prescription of Hydrocodone/bit/apap 5/325mg, #30ms, #30 is medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines p78-80, Opiates, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS has a detailed list of recommendations for initiation and continuation of opioids, and these recommendations do appear to have been addressed by the treating physician in the documentation available for review, especially in the provider note of 7/3/13. I respectfully disagree with the UR physician that these key points were not documented. There is documentation that opiate medications enable the injured worker to have some minimal employment (functional gain) as well as improvement in ADLs, and documents a significant improvement in VAS. To reach the MTUS definition of medical necessity for ongoing treatment, efforts to rule out aberrant behavior (i.e. CURES report, UDS, opiate agreement) and assure safe usage are needed, and these have been completed and documented on that day as well. The dosage is not excessive of this medication, and it meets criteria for medical necessity.

5. One (1) prescription of Sentra PM medical food, #60 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Pain (Chronic), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Compounded Products, pg. 60, which is part of the MTUS

The Physician Reviewer's decision rationale:

Sentra PM contains: Choline Bitartrate, Glutamic Acid, Acetyl L-Carnitine, Ginkgo Biloba, Griffonia Extract (5HTP 95%), Hawthorn Berry, 5-hydroxytryptophan and Cocoa. Marketed for insomnia and nutritional deficiency associated with sleep disorder. MTUS is silent on these ingredients.

The CA MTUS and ACOEM provide no evidence-based recommendations regarding the use of these ingredients. Since they lack affirmative recommendation they do not rise to meet the standards of medical necessity. Note the statement on page 111: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended

Regarding the use of multiple medications, MTUS pg. 60 states "Only one medication should be given at a time and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication.

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[REDACTED]

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