

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/2/2013  
Date of Injury: 5/5/2006  
IMR Application Received: 7/29/2013  
MAXIMUS Case Number: CM13-0004137

- 1) MAXIMUS Federal Services, Inc. has determined the request for **one (1) prescription of Ultram ER 150mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one (1) prescription of Fexmid 7.5mg #60 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 **one (1) prescription of Ultram ER 150mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one (1) prescription of Fexmid 7.5mg #60 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 Family Practice 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.

### **Expert Reviewer Case Summary:**

54-year-old female beneficiary who has a history of shoulder impingement, adhesive capsulitis and acromioclavicular joint osteoarthritis as well as wrist tendinitis and epicondylitis of the right arm. And during the course of her work she has suffered an injury to her left shoulder. In July 2012 she had a flexor tenosynovectomy of the left wrist. Since July 2012 she has to used Zanaflex for her musculoskeletal strains. She was using Norco for sometime in 2012 however she had stopped because it given her side effects of bad dreams. There was noted continuous use of Zanaflex in March through June 2013 as well.

In March 20, 2013 she had arthroscopic surgery of a left rotator cuff with subsequent repair performed. At the time of surgery she also had subacromial decompression of the left shoulder as well as extensive debridement of degenerative findings in the superior labrum.

In April 2013 a progress note from internal medicine noted that there was no evidence of fibromyalgia, rheumatoid arthritis, or rheumatologic disorder related industry xposure. A progress note from me 31<sup>st</sup> 2013 indicate a prescription for cyclobenzaprine 7.5 mg as well asf or Ultram ER 150 mg.A progress note from July 11, 2013 had indicated a prescription for Ultram. The actual indication for specific anatomic pain was not documented.

### **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
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for one (1) prescription of Ultram ER 150mg #60 : Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision**

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

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pg. 264, Initial Care and pg. 278, Further Management, and the Chronic Pain Medical Treatment Guidelines-Opioids, pg 74,75 and 93, which are a part of MTUS.

#### Rationale for the Decision:

According to the ACOEM guidelines pain management for wrist and hand complaints includes nonsteroidal anti-inflammatories and acetaminophen. In addition postoperative management includes encouraging daily exercise. According to the chronic pain medical treatment guidelines chapter on opioid medications indicates that tramadol is a synthetic opioid. It is indicated for moderate to severe pain. Opiates are to be used for neuropathic pain, osteoarthritis, cancer pain or for chronic pain. Short acting opioids are to be used for controlling chronic pain. They are often combined with analgesic such as acetaminophen and aspirin. Long acting or extended release opioids are highly potent form of opioid analgesics. After a review of the records submitted for review, the medical documentation does not indicate specific necessity for tramadol use. The anatomic location for pain relief has not been identified particularly for tramadol use. Pain scale management and failure of other analgesics such as acetaminophen has not been noted. **The requested prescription of Ultram 150mg #60 is not medically necessary and appropriate.**

#### **2) Regarding the request for one (1) prescription of Fexmid 7.5mg #60: Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision**

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

The Expert Reviewer based his/her decision on the Chronic Medical Treatment Guidelines-Antispasmodics pg. 64-66, which is a part of MTUS.

Rationale for the Decision:

As per the chronic pain medical treatment guidelines Fexmid is known as cyclobenzaprine. The medication is indicated for short course therapy. There's no evidence about using it for chronic use. The greatest benefit is seen in the first four days and is associated with symptom improvement at two weeks. A review of the records submitted for review indicate that the employee was on Zanaflex for a long period of time. It is also under the category of anti-spasticity and anti-spasmodic medications. As such Fexmid is similar to Zanaflex. There is significantly more data supporting use of Zanaflex in females with chronic myofascial pain. Fexmid does have some modest benefit in treating fibromyalgia pain. The employee in this case does not have fibromyalgia type pain. **For the reasons stated above the request for Fexmid 7.5 mg #60 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,

Paul Manchester, MD, MPH  
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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