

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/19/2013
Date of Injury:	4/6/2004
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0006511

- 1) MAXIMUS Federal Services, Inc. has determined the request for a cervical epidural injection using fuoroscopy at C5-6 bilaterally **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 4mg **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/12/2013. 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 a cervical epidural injection using fuoroscopy at C5-6 bilaterally **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 4mg **is 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 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.

Expert Reviewer Case Summary:

The 7/17/13 report from Dr [REDACTED], states the low back pain radiating to both lower extremities and neck pain that radiates to both upper extremities. The pain is 9/10 but goes to 8/10 with medications. The report states they reviewed the medications, but did not state what medications the patient was taking. Exam showed lumbar and cervical myofascial tenderness, no change is sensory or motor. Diagnoses include lumbar radiculopathy, cervical radiculitis, chronic pain, and s/p SCS removal due to infection.

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 Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request for a cervical epidural injection using fuoroscopy at C5-6 bilaterally:**

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, Epidural steroid injections (ESIs), pg. 46, which is part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the the Chronic Pain Medical Treatment Guidelines, Epidural steroid injections (ESIs), pg. 46, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The 7/11/13 report requests the cervical ESI. Subjectively there was back pain radiating to the thigh, and neck pain radiating to the shoulder, numbness and tingling in the upper extremity. Medical records submitted and reviewed shows tenderness, no sensory or motor changes. The cervical MRI from 3/1/10 does not show any foraminal narrowing or nerve root compression. Chronic Pain Medical Treatment Guidelines for epidural injections, requires documentation of radiculopathy on physical exam and corroborated with imaging studies. There are no clinical findings of radiculopathy, the subjective complaints were not discussed in a dermatomal distribution, and the MRI does not have any findings consistent with a nerve root compression. The request is not in accordance with MTUS guidelines. **The request for a cervical epidural injection using fluoroscopy at C5-6 bilaterally is not medically necessary and appropriate.**

2) Regarding the request for Tizanidine 4mg:

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, Tizanidine, Muscle relaxants, which are part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle relaxants for pain, pg. 66, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines support the use of Tizanidine for myofascial pain and off label for low back pain. The employee was shown to have myofascial tenderness in the cervical and lumbar regions and the initial prescription for Tizanidine is on the 7/11/13 report. The guideline criteria have been met. **The request for Tizanidine 4mg is 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, 18th Floor
Oakland, CA 94612

/pr

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.