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**Notice of Independent Medical Review Determination**

Dated: 8/16/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

5/3/2013

4/5/2013

5/14/2013

CM13-0000367

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for Cyclobenzaprine 5mg, #30 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 cold/hot Flexipac 8x14 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 lumbar back hugger pillow **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/14/2013 disputing the Utilization Review Denial dated 5/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/8/2013. 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 retrospective request for Cyclobenzaprine 5mg, #30 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 cold/hot Flexipac 8x14 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 lumbar back hugger pillow **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 Occupational 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 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 May 3, 2013:

“The patient is a 46 year old female with a date of injury of 4/5/2013. The provider has submitted retrospective requests for 15 Etodolac 600mg; 30 Cyclobenzaprine 5 mg; 1 Prescription of Polar Frost 150mg 5oz gel tube; 1 Cold/Hot Flexipac 8x14 between 4/15/2013 and 4/15/2013; 1 Lumbar Support Industrial with Susp LG; and 1 Pillow-Lumbar back Hugger all dispensed on 4/15/2013.

“Review of the submitted report dated 4/15/2013 by Dr. [REDACTED], M.D. indicated the patient had fallen at work after her foot became tangled up in plastic. She complained of right-sided lower back pain. On the pain scale it was rated 7/10 and described as moderately severe, dull, constant pain. There was some elbow and knee locking and snapping. She denied any limitation of motion, leg weakness, numbness or tingling. She had been using ice and heat. She was taking ambien, Norco, levothyroxine and advil prior. Examination revealed no issues with gait and she was able to fully weight bear with both lower extremities. There were no spasms of the thoracolumbar or paravertebral musculature only tenderness. Range of motion demonstrated flexion to mid tibia, extension 20/30, right and left lateral flexion 30/45 degrees and rotation bilaterally was 15/30. Achilles and patellar flexes were 2/4 bilaterally. Heel/ toe ambulation as well as sensory intact to light touch and pinprick were normal. Straight

leg raise testing was positive bilaterally at 45 degrees, but no apparent muscle weakness.”

#### **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 5/1/13)
- Utilization Review Determination from [REDACTED] (dated 5/3/13)
- Chronic Pain Medical Treatment Guidelines (2009), Cyclobenzaprine section, pg. 41-42
- American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Chapter 12, Low Back Complaints, pg. 298-301
- Medical Records from [REDACTED] (dated 4/10/13)
- Medical Records from [REDACTED] (dated 4/15/13 – 5/1/13)
- Medical Records from [REDACTED], MD (dated 5/9/13 – 6/27/13)

#### **1) Regarding the retrospective request for Cyclobenzaprine 5mg, #30 :**

##### 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), Cyclobenzaprine section, pg. 41-42, part of the Medical Treatment Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. 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 to the low back and right knee on 4/5/13 resulting in low back, right hip, thigh, and knee pain. Medical records provided and reviewed indicate treatment included; X-rays of the lumbar spine and knee, which showed no evidence of acute bony trauma; joint spaces were well maintained; analgesics; and application of heat and ice. An orthopedic consultation on 5/9/13 notes the employee continues to experience back, right thigh and knee pain. A retrospective request for Cyclobenzaprine 5mg, #30, 1 cold/hot Flexipac 8x14 and 1 lumbar back hugger pillow was submitted.

MTUS Chronic Pain Guidelines state Cyclobenzaprine “is a skeletal muscle relaxant and a central nervous system depressant.” The main use for muscle relaxants is to relieve muscle spasms. The medical records submitted for this review indicate the employee is experiencing paraspinal pain. There is no evidence of muscle spasms. The retrospective request for Cyclobenzaprine 5mg, #30 **is not medically necessary and appropriate.**

## 2) Regarding the retrospective request for 1 cold/hot Flexipac 8x14 :

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Chapter 12, Low Back Complaints Chapter, pg. 300, part of the Medical Treatment Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) (2007), Low Back Complaints Chapter, Cold pack section, a Medical Treatment Guideline (MTG) not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the MTUS 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 to the low back and right knee on 4/5/13 resulting in low back, right hip, thigh, and knee pain. Medical records provided and reviewed indicate treatment included; X-rays of the lumbar spine and knee, which showed no evidence of acute bony trauma; joint spaces were well maintained; analgesics; and application of heat and ice. An orthopedic consultation on 5/9/13 notes the employee continues to experience back, right thigh and knee pain. A retrospective request for Cyclobenzaprine 5mg, #30, 1 cold/hot Flexipac 8x14 and 1 lumbar back hugger pillow was submitted.

MTUS ACOEM guidelines recommend "at home local applications of cold in the first few days of acute complaint and application of heat and cold thereafter." The Flexipac will allow for the application of both heat and cold therapy as needed for discomfort. The retrospective request for 1 cold/hot Flexipac 8x14 is **medically necessary and appropriate**

## 3) Regarding the retrospective request for 1 lumbar back hugger pillow:

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Chapter 12, Low Back Complaints Chapter, pg. 298, 301, part of the MTUS and Official Disability Guidelines (ODG) (2009), Low Back, Lumbar and Thoracic, Lumbar Support Section, a MTG not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the MTUS 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 to the low back and right knee on 4/5/13 resulting in low back, right hip, thigh, and knee pain. Medical records provided and reviewed indicate treatment included; X-rays of the lumbar spine

and knee, which showed no evidence of acute bony trauma; joint spaces were well maintained; analgesics; and application of heat and ice. An orthopedic consultation on 5/9/13 notes the employee continues to experience back, right thigh and knee pain. A retrospective request for Cyclobenzaprine 5mg, #30, 1 cold/hot Flexipac 8x14 and 1 lumbar back hugger pillow was submitted.

MTUS ACOEM guidelines do not recommend “lumbar supports beyond the acute phase” and there is a lack of evidence supporting their use for relief of low back pain. There is no indication on the medical records that the employee is experiencing positional sleep difficulties. The request for 1 lumbar back hugger pillow **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.