
Notice of Independent Medical Review Determination

Dated: 8/30/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

5/6/2013

2/3/2013

5/28/2013

CM13-0000499

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy for the spine and bilateral shoulders 2 times a week for 4 weeks **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an MRI of the lumbar spine **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Flurbiprofen/Cyclobenzaprine 1x6 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/28/2013 disputing the Utilization Review Denial dated 5/6/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/15/2013. 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 physical therapy for the spine and bilateral shoulders two (2) times a week for four (4) weeks **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an MRI of the lumbar spine **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Flurbiprofen/Cyclobenzaprine 1x6 **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 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 May 6, 2013:

“PR-2 dated 4/12/13 indicates that the claimant presents with complaints of pain in the neck, mid back, low back, bilateral wrist, bilateral leg, and feet. Examination of the cervical spine and upper extremities reveals tenderness in the bilateral trapezius muscles. Range of motion in flexion is 35 degrees, extension is 40 degrees, bilateral lateral bending is 40 degrees, and bilateral rotation is 60 degrees. Cervical compression and distraction test is positive. There is tenderness in the bilateral anterior glenoid. Right shoulder range of motion in flexion is 160 degrees, extension is 45 degrees, abduction is 20 degrees, adduction is 20 degrees, internal rotation is 60 degrees, and external rotation is 70 degrees. Examination of the thoracic/lumbar and lower extremities reveals tenderness in the bilateral multifidus. Range of motion in flexion is 35 degrees, extension is 10 degrees, and bilateral lateral bending is 15 degrees. Lasegue’s test is positive bilaterally with pain in the posterior calf. Provider recommends medications in the form of Ultram 50mg one by mouth twice daily, Motrin 800mg one by mouth twice daily with food, and FluriFlex (Flurbiprofen 15 percent/Cyclobenzaprine 10 percent). Provider recommends physiotherapy twice per week for 4 weeks to the neck, mid back, low back and bilateral shoulder. The claimant has been instructed to return to modified work on 4/15/13 with restrictions to no lifting or pushing over 10 pounds, no

repetitive bending or stooping, no repetitive forceful, activities with bilateral upper extremities. If modified work is not available then the claimant remains temporarily totally disabled.”

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 5/28/13)
- Utilization Review Determination (dated 5/6/13)
- Chronic Pain Medical Treatment Guidelines (2009), Physical Medicine, pgs 98-99
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, page 303
- Official Disability Guidelines (ODG) current edition, TWC Pain Procedure Summary, Topical analgesics
- Comprehensive Orthopaedic Consultation Report from [REDACTED], MD (dated 3/15/13)
- PR-2 Report from [REDACTED], MD (dated 4/12/13)
- Report of Work Capabilities from [REDACTED] (dated 3/14/13)
- MRI of Lumbar Spine Results from [REDACTED] (dated 3/26/13)
- Toxicology Report from [REDACTED] (dated 5/24/13)
- Thoracic/Lumbar & Lower extremities progress report, Cervical & Upper extremities progress report (dated 4/12/13)

1) Regarding the request for physical therapy for the spine and bilateral shoulders two (2) times a week for four (4) weeks :

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), Physical Medicine, pgs 98-99, of the Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) (current version), Neck and Upper Back Chapter, Low Back Chapter, and Shoulder Chapter, Physical Therapy Sections, 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 no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the ODG guidelines used by the Claims Administrator and the ODG preface for Physical Therapy Guidelines, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 2/3/13 the employee sustained an industrial injury. Medical records submitted and reviewed indicate treatment has included X-rays and medications. An orthopedic consultation dated 5/15/13 indicates the employee continues to experience headaches, pain in the neck, mid back, low back and waist. A request was submitted for physical therapy for the spine and bilateral shoulders, 2 times a week for 4 weeks.

CA MTUS Chronic Pain guidelines do not specifically address the number of physical therapy sessions recommended for an initial course of treatment. Official Disability guidelines state that patients should be assessed after a trial of six (6) visits for objective evidence of improvement. A review of the medical records indicates the employee has functional deficits with decreased range of motion, but the request for a total of eight (8) sessions of physical therapy exceeds evidenced based guidelines suggested for an initial course of treatment. The request for physical therapy for the spine and bilateral shoulders two (2) times a week for four (4) weeks is not medically necessary and appropriate.

2) Regarding the request for an MRI of the lumbar spine :

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), 2nd Edition, (2004), Chapter 12, page 303, part of the Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG), (current version), Low Back Procedure Summary, 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 ACOEM guidelines used by the Claims Administrator, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 2/3/13 the employee sustained an industrial injury. Medical records submitted and reviewed indicate treatment has included X-rays and medications. An orthopedic consultation dated 5/15/13 indicates the employee continues to experience headaches, pain in the neck, mid back, low back and waist. A request was submitted for an MRI of the lumbar spine.

MTUS ACOEM guidelines suggest MRI imaging may be considered if there is physiologic evidence to indicate tissue insult or nerve impairment. A medical report dated 03/15/13 did not reveal any significant neurological deficits, such as motor weakness or reflex changes. The primary treating physician's progress report dated 04/12/13 indicates mid back and low back pain as well as bilateral leg pain and bilateral feet pain, but there is no documentation of significant progressive neurological deficits. The request for an MRI of the lumbar spine is not medically necessary and appropriate.

3) Regarding the request for Flurbiprofen/Cyclobenzaprine 1x6 :

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) current edition, TWC Pain Procedure Summary, Topical Analgesics, a medical treatment guideline (MTG), not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain guidelines,

(2009), Topical Analgesics, pg. 111, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 2/3/13 the employee sustained an industrial injury. Medical records submitted and reviewed indicate treatment has included X-rays and medications. An orthopedic consultation dated 5/15/13 indicates the employee continues to experience headaches, pain in the neck, mid back, low back and waist. A request was submitted for Flurbiprofen/Cyclobenzaprine 1x6.

MTUS Chronic Pain guidelines state that topical analgesics are largely experimental with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical records reviewed failed to demonstrate use of oral medications including antidepressants or anticonvulsants. The guidelines also state, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended". The guidelines do not recommend the use of Cyclobenzaprine (a muscle relaxant) for topical use. The request for Flurbiprofen/Cyclobenzaprine 1x6 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, 18th 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.