
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]

7/2/2013

11/24/1992

7/3/2013

CM13-0000947

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 medium firmness orthopedic mattress **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Valium tablets **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Zanaflex tablets **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Duragesic **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Norco **is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Prilosec **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/3/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/5/2013. 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 1 medium firmness orthopedic mattress **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Valium tablets **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Zanaflex tablets **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Duragesic **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Norco **is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for Prilosec **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 July 2, 2013:

“CLINICAL SUMMARY:

██████████ is a 56 year old (DOB: 8/22/56) female who sustained a work injury on 11/24/92 injuring her lower back. Mechanism of injury, occupation and current work status was not found in records reviewed. Lower back area, mental/physical, and spinal cord (neck) have been accepted by the carrier.

“PRIOR UR:

01/29/13 ██████████, M.D.; ██████████ CERTIFIED: Left L4-5 foraminotomy. Urology Consult. Lumbar spine brace repair.

“DIAGNOSTICS: None found in reports reviewed
-see notes from 06/03/13 [REDACTED], M.D.

“PRIOR SURGERY/PROCEDURE:

-03/01/10 [REDACTED], M.D.; Anterior lumbar interbody fusion at the L4-L5 level
-09/21/11 [REDACTED], M.D.; Epidural injection left L3-L4. Epidurogram at L3-L4.
Bilateral facer blocks at L3-L4.”

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
- Utilization Review Determination by [REDACTED] (dated 7/2/13)
- Utilization Review by [REDACTED] (dated 1/30/13)
- Requests for Continued Medical Treatment by Dr. [REDACTED] MD, PhD (dated 12/3/12 to 6/3/13)
- Medial Records by [REDACTED] (dated 6/4/12 to 6/3/13)
- Medial Reevaluation by [REDACTED], MD (dated 7/12/11)
- Radiologist Report by [REDACTED] (dated 2/14/12)
- Procedure Notes by [REDACTED] (dated 7/17/00 to 4/13/05)
- Operation Notes by [REDACTED] (dated 3/1/10 to 5/10/10)
- Progress Note and Prescription by Dr. [REDACTED], M.D. (dated 4/1/13)
- Medical Records by [REDACTED] (dated 7/14/12 to 7/21/12)
- Operative Report by [REDACTED] (dated 6/24/97)
- Operative Report by [REDACTED] (dated 9/1/98)
- Official Disability Guidelines (ODG) – Low Back Chapter, Mattress section
- Chronic Pain Medical Treatment Guidelines (2009), pages 23, 44, 47, 66, 80-81

1) Regarding the request for 1 medium firmness orthopedic mattress:

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) – Low Back Chapter, Mattress section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined that the MTUS does not address the requested treatment. The Expert Reviewer relied on the American College of Occupational and Environmental Medicine Guidelines – 3rd Edition, Chronic Pain section, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:

The employee was injured on 11/24/1992 and has experienced chronic low back pain, chronic neck pain, and depressive disorder associated with cumulative trauma. Treatment to date has included analgesic medications, adjuvant medications, long and short acting opioids, lumbar brace, psychological counseling, multiple spine surgeries, and extensive time off work. A request was submitted for 1 medium firmness orthopedic mattress.

The MTUS does not address the topic. The ACOEM Guidelines – 3rd Edition, Chronic Pain section indicates that specific beds and/or commercial sleep products are not recommended for the treatment of chronic pain syndrome, as is present here in this employee. The request for 1 medium firmness orthopedic mattress is not medically necessary and appropriate.

2) Regarding the request for Valium tablets:

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), page 23, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, pages 23 and 124, which are part of the MTUS.

Rationale for the Decision:

The employee was injured on 11/24/1992 and has experienced chronic low back pain, chronic neck pain, and depressive disorder associated with cumulative trauma. Treatment to date has included analgesic medications, adjuvant medications, long and short acting opioids, lumbar brace, psychological counseling, multiple spine surgeries, and extensive time off work. A request was submitted for Valium tablets.

The Chronic Pain Medical Treatment Guidelines do not endorse longstanding or chronic usage of benzodiazepines for sleep, pain, anxiety or any another purpose. The request for Valium tablets is not medically necessary and appropriate.

3) Regarding the request for Zanaflex tablets:

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), page 66, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 11/24/1992 and has experienced chronic low back pain, chronic neck pain, and depressive disorder associated with cumulative trauma. Treatment to date has included analgesic medications, adjuvant medications, long and short acting opioids, lumbar brace, psychological counseling, multiple spine surgeries, and extensive time off work. A request was submitted for Zanaflex tablets.

The MTUS Chronic Pain Medical Guidelines do suggest that tizanidine or Zanaflex can be employed in the treatment of low back pain. Tizanidine is FDA approved for the management of spasticity, but not chronic low back pain. In this case, there is no evidence of functional improvement through prior usage of tizanidine. The employee has failed to return to work or demonstrate any evidence of functional improvement as defined in MTUS 9792.20f. The request for Zanaflex tablets is not medically necessary and appropriate.

4) Regarding the request for Duragesic:

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), pages 44 and 47, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 11/24/1992 and has experienced chronic low back pain, chronic neck pain, and depressive disorder associated with cumulative trauma. Treatment to date has included analgesic medications, adjuvant medications, long and short acting opioids, lumbar brace, psychological counseling, multiple spine surgeries, and extensive time off work. A request was submitted for Duragesic.

The medical records submitted for review indicate the employee has used this Duragesic chronically and has failed to derive any lasting benefit or functional improvement. The MTUS Chronic Pain Medical Treatment Guidelines criteria for continuation of opioids includes evidence of increased functioning and decreased pain and/or successful return to work through usage of opioid analgesic. In this case, the employee has not met the criteria for continued usage. The employee continues to report heightened pain and has failed to return to work. In terms of activities of daily living, the employee is limited and continues to use a walker and other assistive devices. The request for Duragesic is not medically necessary and appropriate.

5) Regarding the request for Norco:

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), page 80, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 11/24/1992 and has experienced chronic low back pain, chronic neck pain, and depressive disorder associated with cumulative trauma. Treatment to date has included analgesic medications, adjuvant medications, long and short acting opioids, lumbar brace, psychological counseling, multiple spine surgeries, and extensive time off work. A request was submitted for Norco.

The medical records submitted for review indicate the employee has failed to derive any lasting benefit or functional improvement through the usage of the opioid agents in question. The employee has failed to return to work, and is slowly demonstrating increased function and decreased strength through usage of Norco. The request for Norco is not medically necessary and appropriate.

6) Regarding the request for Prilosec:

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), pages 80-81, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 11/24/1992 and has experienced chronic low back pain, chronic neck pain, and depressive disorder associated with cumulative trauma. Treatment to date has included analgesic medications, adjuvant medications, long and short acting opioids, lumbar brace, psychological counseling, multiple spine surgeries, and extensive time off work. A request was submitted for Prilosec.

The MTUS Chronic Pain Guidelines indicate a proton-pump inhibitor such as Prilosec can be employed in the treatment of dyspepsia. In this case, there is no evidence or documentation of issues with dyspepsia, reflux, heartburn, etc., which might allow for usage of Prilosec. The request for Prilosec 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

/dj

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.