

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/10/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/5/2013
Date of Injury: 7/9/2010
IMR Application Received: 7/18/2013
MAXIMUS Case Number: CM13-0002017

- 1) MAXIMUS Federal Services, Inc. has determined the request for Naproxen 550mg #60 with 1 refill **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg #30 with 1 refill **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 4mg #60 with 1 refill **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 Naproxen 550mg #60 with 1 refill **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg #30 with 1 refill **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 4mg #60 with 1 refill **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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 8, 2013:

The patient is a 51 year old male with a date of injury of 7/9/2010. Under consideration are prospective requests for a prescription of naproxen with one refill, a prescription of omeprazole with one refill, a prescription of tramadol with one refill, and a prescription of tizanidine with one refill.

The submitted documents indicated that the patient was being treated for neck, low back, and bilateral hip pain. The examination conducted by [REDACTED] MD on 7/2/2013 revealed cervical and lumbar spine pain both rated 7.5 out of 10. Pain in the right hip was rated 4 out of 10 and the left hip was rated 7.5 out of 10. The pain was constant, burning, stinging, sharp, and throbbing. When waking in morning,

he experienced weakness and numbness. Physical examination was unchanged. Cervical spine range of motion was restricted in all ranges, lumbar spine range of motion was restricted in flexion and extension, and both hips were restricted in flexion, abduction, internal rotation, and external rotation. His diagnoses included multilevel cervical spine disc bulges, multilevel lumbar spine disc bulges, lumbar spine radiculopathy, bilateral hip impingement, and lumbago. Treatments to date consisted of physical therapy, chiropractic, three epidural steroid injections, one thoracic injection, and medications. He was instructed to return to full duty on 7/2/2013.

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 07/18/2013)
- Utilization Review from [REDACTED] (dated 07/08/2013)
- Medical Records from Claims Administrator [REDACTED] (dated 07/29/2013)
- Medical treatment Utilization Schedule

1) Regarding the request for Naproxen 550mg #60 with 1 refill :

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), Non-Steroidal Anti-Inflammatory Drugs section, 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 (2009), page 22, which is part of the MTUS.

Rationale for the Decision:

The employee was injured on 7/9/2010 and reports neck, low back and bilateral hip pain. Physical examination on 7/2/2013 revealed cervical spine and lumbar spine pain verbalized as 7.5/10 on the visual analog scale. Objective evaluation noted cervical spine range of motion was restricted in all ranges with lumbar spine range of motion restricted in flexion and extension and range of motion of the bilateral hips restricted in flexion, abduction, internal rotation, and external rotation. The employee has been treated with physical therapy, chiropractic therapy, 3 epidural steroid injections, 1 thoracic injection, and medication management. A request was submitted for Naproxen 550mg #60 with 1 refill.

The MTUS Chronic Pain Medical Treatment Guidelines indicate anti-inflammatory medications are a first-line of treatment to reduce pain so activity and functional restoration can resume. However, long-term use may not be warranted. Further, a comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concluded that available evidence supported the effectiveness of non-steroidal anti-inflammatory drugs (NSAIDs) in chronic low back pain. The documentation submitted for review indicated the employee has multiple complaints of pain regarding the neck, low back, and bilateral hips with limited range of motion noted in the cervical spine and lumbar spine, as well as the bilateral hips. Given the recommendation of the guidelines for NSAIDs as the traditional first-line of treatment, the request for naproxen 550 mg #60 with 1 refill is indicated. The request for Naproxen 550mg #60 with 1 refill **is medically necessary and appropriate.**

2) Regarding the request for Omeprazole 20mg #30 with 1 refill :

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), but did not cite a specific section, 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 relied on the Chronic Pain Medical Treatment Guidelines (2009), page 68, which is part of the MTUS.

Rationale for the Decision:

The employee was injured on 7/9/2010 and reports neck, low back and bilateral hip pain. Physical examination on 7/2/2013 revealed cervical spine and lumbar spine pain verbalized as 7.5/10 on the visual analog scale. Objective evaluation noted cervical spine range of motion was restricted in all ranges with lumbar spine range of motion restricted in flexion and extension and range of motion of the bilateral hips restricted in flexion, abduction, internal rotation, and external rotation. The employee has been treated with physical therapy, chiropractic therapy, 3 epidural steroid injections, 1 thoracic injection, and medication management. A request was submitted for Omeprazole 20mg #30 with 1 refill.

The MTUS Chronic Pain Medical Treatment Guidelines recommend use of proton pump inhibitors such as Omeprazole for patients at intermediate risk for gastrointestinal events. The records submitted and reviewed lack evidence of current gastrointestinal symptoms. Given the absence of an indication for proton pump inhibitor, Omeprazole is not indicated for this employee. The request for Omeprazole 20mg #30 with 1 refill **is not medically necessary and appropriate.**

3) Regarding the request for Tizanidine 4mg #60 with 1 refill :

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), Tizanidine section, 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 guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 7/9/2010 and reports neck, low back and bilateral hip pain. Physical examination on 7/2/2013 revealed cervical spine and lumbar spine pain verbalized as 7.5/10 on the visual analog scale. Objective evaluation noted cervical spine range of motion was restricted in all ranges with lumbar spine range of motion restricted in flexion and extension and range of motion of the bilateral hips restricted in flexion, abduction, internal rotation, and external rotation. The employee has been treated with physical therapy, chiropractic

therapy, 3 epidural steroid injections, 1 thoracic injection, and medication management. A request was submitted for Tizanidine 4mg #60 with 1 refill.

The MTUS Chronic Pain Medical Treatment Guidelines indicate Tizanidine is FDA approved for the management of spasticity with unlabeled use for low back pain. Tizanidine is a centrally acting alpha II adrenergic agonist which has demonstrated efficacy for low back pain. However, while guidelines indicate that this medication may be useful in the treatment of chronic low back pain, the documentation submitted and reviewed fails to detail muscle spasms noted on physical examination. The request for Tizanidine 4mg #60 with 1 refill **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

/sab

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.