

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/2/2013
Date of Injury: 1/4/2008
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0006528

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 33-year-old male who reported an injury on 01/04/2008. Current diagnoses include lumbar postlaminectomy syndrome and lumbar radiculopathy. The patient was most recently seen on 09/13/2013 by Dr. [REDACTED]. Physical examination revealed tenderness to palpation, myofascial trigger points bilaterally, and moderate limitation of range of motion of the lumbar spine secondary to pain. The patient was given trigger point injections on that date. Treatment plan included continuation of current medications, including Norco, Gabapentin, and tizanidine.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Thirty (30) Gabapentin 600 mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the California Chronic Pain Medical Treatment Guidelines, May 2009, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antiepilepsy drugs (AEDs), pg 16-19, which is part of the MTUS

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that antiepilepsy medication is recommended for neuropathic pain. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first line treatment for neuropathic pain. Gabapentin is recommended as a trial for lumbar spinal stenosis. One recommendation for an adequate trial with Gabapentin is 3 to 8 weeks for titration, then 1 to 2 weeks at maximum tolerated dosage. The patient should be asked at each visit as to whether there has been a change in pain or function. If inadequate control of pain is found, a switch to another first line drug is recommended. In this case, the clinical notes submitted reflect that the employee demonstrated tenderness to palpation with decreased range of motion and myofascial trigger points on examination. The employee reported an increase in pain despite the prolonged previous use of Gabapentin. There were no documented reports of benefit or significant improvement as the direct result of this medication use. Multiple prior requests for Gabapentin have also been recommended as non-certified due to the employee's lack of improvement with use of this medication. Based on the absence of any significant functional improvement and in accordance with the Chronic Pain Guidelines, the request is non-certified. **The request for thirty (30) Gabapentin 600 mg is not medically necessary and appropriate.**

2. One hundred and fifty (150) Norco 10-325 mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the California Chronic Pain Medical Treatment Guidelines, May 2009, which is part of the MTUS. .

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pg 74-82, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that short acting opioids are often used for intermittent or breakthrough pain. The duration of action is generally 3 to 4 hours. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the clinical notes submitted reflect that despite the previous use of Norco, there was no documented functional improvement or significant decrease in pain level reported since the last office visit. The employee has been using opioids for a prolonged period of time; however, the pain has increased. The employee does not currently meet any of the criteria for continuation of opioids for management of chronic pain. The provider was previously urged to initiate weaning and tapering of opioids in previous reviews. No documented attempt of weaning or tapering was present. Based on the clinical information received and the Chronic Pain Guidelines, the request is non-certified. **The request for one hundred and fifty (150) Norco 10-325 mg is not medically necessary and appropriate.**

3. Ninety (90) Tizanidine HCL 4 mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the California Chronic Pain Medical Treatment Guidelines, May 2009, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for pain), pg 63-66, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations in patients with chronic low back pain. However, in lower back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. Tizanidine is approved for the management of spasticity. In this case, the clinical notes submitted reflect that despite the previous prolonged use of tizanidine, there has been no documented significant functional improvement as a direct result of this muscle relaxant. Due to the adverse side effects, it did not appear to be beneficial to this employee to continue the use of this muscle relaxant in the absence of severe symptoms or improvements. Physical examination revealed tenderness to palpation, decreased range of motion, and trigger points. Based on the clinical information received and the Chronic Pain Guidelines, continuation of this medication cannot be determined as medically appropriate. **The request for Ninety (90) Tizanidine HCL 4 mg is not medically necessary and appropriate.**

/pas

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.

[REDACTED]
[REDACTED]
[REDACTED]

CM13-0006528