MAXIMUS Federal Services

Case Number:	CM14-0200793		
Date Assigned:	12/11/2014	Date of Injury:	12/21/2006
Decision Date:	01/28/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	12/01/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

The applicant is a represented [redacted] employee who has filed a claim for chronic neck pain reportedly associated with an industrial injury of December 21, 2006.In a Utilization Review Report dated October 28, 2014, the claims administrator partially approved a request for trazodone for weaning purposes, denied tizanidine, approved a CPAP mask, and denied an interferential stimulator device with associated electrodes and pads. The claims administrator noted that the applicant had issues with major depressive disorder and reportedly severe obstructive sleep apnea. The claims administrator stated that the applicant had undergone earlier cervical spine surgery and earlier shoulder surgery. The claims administrator also suggested that the applicant had previously received a TENS unit. The claims administrator stated that it was partially approving trazodone for weaning purposes as the trazodone was an ODG non-formulary article. The claims administrator referenced progress notes of September 24, 2014, July 23, 2014, June 11, 2014, and April 9, 2014 in its determination.The applicant's attorney subsequently appealed.On April 9, 2014, the applicant reported ongoing complaints of neck pain, shoulder pain, wrist pain, and headaches. The applicant also had issues with severe obstructive sleep apnea. The applicant was asked to pursue acupuncture. A filter for CPAP mask was endorsed along with electrodes and batteries for the applicant's interferential stimulator device. A rather proscriptive 10-pound lifting limitation was endorsed. It was not clearly stated whether the applicant was or was not working with said limitations in place, although this did not appear to be case. Maxalt, Topamax, Norco, Wellbutrin, ranitidine, and tizanidine were refilled. It was stated that tizanidine was being employed for pain and sleep purposes. The applicant was described as having issues with depression, social dysfunction, and sleep disturbance for which trazodone was being employed, it was suggested.The applicant went on to receive acupuncture in June 2014.In a January 8, 2014 supplemental report, it was

suggested that the applicant had been off of work, on total temporary disability, during large portions of the claim.The remainder of the file was surveyed. The progress notes of September 24, 2014, July 29, 2014, and June 11, 2014 seemingly made available to the claims administrator did not appear to have been incorporated into the Independent Medical Review packet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of interferential unit, electrodes and pads: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 120.

Decision rationale: The attending provider suggested on an earlier progress note dated April 9, 2014 that the applicant had previously been given interferential unit. Page 120 of the MTUS Chronic Pain Medical Treatment Guidelines stipulates that usage of an interferential unit device beyond an additional one-month trial should be predicated on evidence of a favorable outcome during said one-month trial, in terms of both pain relief and function. In this case, however, the applicant is seemingly off of work. A rather proscriptive 10-pound lifting limitation remains in place. The applicant remains dependent on opioid agents such as Norco and non-opioid agents such as Tizanidine. All of the foregoing, taken together, suggests a lack of functional improvement as defined in MTUS 9792.20f, despite prior usage of the interferential unit. Therefore, the request is not medically necessary.

Trazadone 100mg #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressant. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 15 Stress Related Conditions Page(s): 402; 47.

Decision rationale: While the MTUS Guideline in ACOEM Chapter 15, page 402 does acknowledge that antidepressants such as Trazodone may be helpful to alleviate symptoms of depression, as are/were present here, this recommendation, however, is qualified by commentary made in ACOEM Chapter 3, page 47 to the effect that an attending provider should incorporate some discussion of "efficacy of medication" into his choice of recommendations. The April 9, 2014 progress note suggested that the applicant was having ongoing issues with depression, social dysfunction, and sleep disturbance. It is not clearly stated or established whether or not ongoing usage of Trazodone was proving helping in ameliorating or attenuating the applicant's symptoms of depression. The information which is on file failed to support or substantiate the request. Therefore, the request is not medically necessary.

Tizanidine 4mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Sedating Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine/Zanaflex; Functional Restoration Approach to Chronic Pain Management Page(s): 66; 7.

Decision rationale: While page 66 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that Tizanidine is FDA approved in the management of spasticity but can be employed off-label for low back, in this case, however, the applicant was described on the April 9, 2014 office visit, referenced above, as experiencing issues with headaches, neck pain, shoulder pain, and carpal tunnel syndrome. There was no mention of back pain for which off-label usage of Tizanidine could have been considered. It is further noted that this recommendation is qualified by commentary made on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of medication efficacy into his choice of recommendations. Here, however, the applicant is seemingly off of work. A rather proscriptive 10-pound lifting limitation remains in place, unchanged, from visit to visit. The applicant remains dependent on opioid agents such as Norco. All of the foregoing, taken together, suggests a lack of functional improvement as defined in MTUS 9792.20f, despite ongoing usage of Tizanidine. Therefore, the request was not medically necessary.