

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested Bio Therm (Capsaicin 0.002%) 4 oz **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Diclofenac 10% /Cyclobenzaprine 10% /Lidocaine 5% (Diclofenac Flex Plus) **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/10/2013 disputing the Utilization Review Denial dated 5/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/11/2013. 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 requested Bio Therm (Capsaicin 0.002%) 4 oz is medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the requested Diclofenac 10% /Cyclobenzaprine 10% /Lidocaine 5% (Diclofenac Flex Plus) is not medically necessary and appropriate.

Medical Qualifications of the Professional 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 professional 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 15, 2013.

“Clinical Summary: This 53-year-old female injured herself on 1/2/13. The mechanism of injury occurred while she was working in the kitchen. She slipped and fell on a wet floor. She attempted to break her fall with her left arm and landed on her bilateral knees. Her diagnoses were rotator cuff syndrome of the shoulder and allied disorders, superior glenoid labrum lesion, and sprain of the wrist. The patient was seen by Dr. [REDACTED] on 3/28/13. She complained of constant moderate neck pain. The pain was sharp and she rated it a 7/10 on a pain scale. She complained of moderate intermittent pain to the left shoulder which radiated down her left extremity to her hand. The pain was burning and stabbing. She rated the pain at a 7/10. She complained of moderate pain to her left extremity with the upper arm pain radiating down to her elbow, wrist, and fingers. She had numbness and tingling to her hand including all digits. She rated the pain at a 7/10. She complained of stomach discomfort, heartburn, and acid reflux. She appeared in no distress and moved around without difficulty. The physical examination revealed limited range of motion of the lumbar spine. Flexion was 40 degrees, extension 50 degrees, right rotation 60 degrees, left rotation 45 degrees, right lateral flexion 40 degrees, and left lateral flexion 35 degrees. There was tenderness to palpation (TIP) of the suboccipital region. There was TIP of the cervical paravertebral muscles bilaterally, and there was hypertonicity on the left side. There was TIP of the levator scapulae on the left side. Cervical compression and cervical distraction tests were negative. Spurling's test was positive bilaterally. The shoulder depression test was positive on the left side. There was TIP of the trapezius muscle bilaterally, and there was hypertonicity on the left side. There was TIP of the subacromial spine, and there was hypertonicity on the left side. There was TIP of the biceps tendon and the acromioclavicular joint on the left side. Supraspinatus, Neer's impingement, and Hawkins impingement tests were positive on

the left side. Muscle strength was 4/5 with flexion and extension on the left side. Phalen's and Finkelstein's tests were positive on the left side. Muscle strength was 4/5 with flexion and extension on the left. There was 5/5 muscle strength on the right. Grip strength was 25/30/25 on the right and 15/10/ 10 on the left. The plan was to prescribe a left wrist brace. A request for authorization was made for an MRI of the left shoulder. The patient was dispensed a prescription for Ultram. The above stated topical compounds were also prescribed by the provider.”

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 by [REDACTED] (dated 5/15/13)
- Doctor's First Report of Occupational Injury or Illness by [REDACTED], MD (dated 1/2/13)
- Doctor's First Report of Occupational Injury or Illness by [REDACTED], MD (dated 3/28/13)
- Lab Report by [REDACTED] (dated 3/28/13)
- Medical Treatment Authorization form by [REDACTED] (dated 1/17/13 thru 5/21/13)
- Employee's Medical Records by [REDACTED] (dated 1/2/13 thru 2/27/13)
- Employee's Medical Records by [REDACTED] (dated 3/5/13)
- Employee's Medical Records by [REDACTED] (dated 3/28/13 thru 5/30/13)
- Diagnostic Imaging Report by [REDACTED] (dated 2/26/13)
- Employee's Medical Records by [REDACTED] (dated 5/21/13)
- Chronic Pain Medical Treatment Guidelines – Division of Workers' Compensation and Official Disability Guidelines References (May 2009), pg 28-29, & 111-113

1) Regarding the Request for Bio Therm (Capsaicin 0.002%) 4 oz :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines – Division of Workers' Compensation and Official Disability Guidelines References (May 2009), pg 28-29, & 111-113, of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision

This 53-year-old female injured herself on 1/2/13. The mechanism of injury occurred while she was working in the kitchen. She slipped and fell on a wet floor. She attempted to break her fall with her left arm and landed on her bilateral knees. Her diagnoses were rotator cuff syndrome of the shoulder and allied disorders, superior glenoid labrum lesion, and sprain of the wrist. The patient was seen by Dr. [REDACTED] on 3/28/13, 4/25/13, and again on 5/30/13. Per the medical

records dated 5/30/13, the patient presents with continued left shoulder pain. She has failed conservative care including injections, and at this point is in fact indicated for left shoulder operative arthroscopy. Per the employee, she reports using Bio-Therm topical cream once a day seems to improve her symptoms. Per Chronic Pain Medical Treatment Guidelines, Capsaicin, topical is recommended only as an option in patients who have not responded or are intolerant to other treatments, therefore, the request for Bio Therm (Capsaicin 0.002% 4 oz. is medically necessary and appropriate.

2) Regarding the Request for Diclofenac 10% /Cyclobenzaprine 10% /Lidocaine 5% (Diclofenac Flex Plus):

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines – Division of Workers’ Compensation and Official Disability Guidelines References (May 2009), pg 28-29, & 111-113, of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision

The employee injured herself on 1/2/13. The mechanism of injury occurred while she was working in the kitchen. She slipped and fell on a wet floor. She attempted to break her fall with her left arm and landed on her bilateral knees. Her diagnoses were rotator cuff syndrome of the shoulder and allied disorders, superior glenoid labrum lesion, and sprain of the wrist. The patient was seen by Dr. [REDACTED] on 3/28/13, 4/25/13, and again on 5/30/13. Per the medical records dated 5/30/13, the patient presents with continued left shoulder pain. She has failed conservative care including injections, and at this point is in fact indicated for left shoulder operative arthroscopy. The request is for Diclofenac 10% /Cyclobenzaprine 10% /Lidocaine 5% (Diclofenac Flex Plus). Per Chronic Pain Medical Treatment Guidelines of the MTUS, topical NSAIDs are effective treatment for musculoskeletal pain, but effectiveness of compounded product is questionable. Therefore, the requested Diclofenac 10% /Cyclobenzaprine 10% /Lidocaine 5% (Diclofenac Flex Plus) 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

/ldh

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.