
Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 6/3/2013
Date of Injury: 2/14/2013
IMR Application Received: 6/11/2013
MAXIMUS Case Number: CM13-0000640

- 1) MAXIMUS Federal Services, Inc. has determined the request for **unknown amount of Terocin is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Omeprazole 20mg #60 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine 7.5mg #60 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Tylenol #3 #60 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **TENS unit is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **1 wrist splint is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **1 ultrasound is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for **1 paraffin bath is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/11/2013 disputing the Utilization Review Denial dated 6/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/19/2013. 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 **unknown amount of Terocin is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Omeprazole 20mg #60 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine 7.5mg #60 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Tylenol #3 #60 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **TENS unit is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **1 wrist splint is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **1 ultrasound is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for **1 paraffin bath 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.

Expert Reviewer Case Summary:

The patient is a 47-year-old female with a work injury date of February 14, 2013. Patient says she cut her finger while at work. X-ray was negative. Diagnosis was finger wound, nail without complications patient was treated with NSAIDs and antibiotics NSAIDs were reported to make the patient dizzy the patient was switched to Norco on 2/13/13 because she complained of too much pain. Physical exam was otherwise normal. The patient was crying in the office. Patient was sent to hand therapy in may

2013. Diagnosis was fasciitis/tendinitis, myositis of the left hand, status post compound fracture of left finger. There are no records to indicate that a fracture had taken place.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for unknown amount of Terocin:

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

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

The Expert Reviewer based his/her decisions on the Chronic Pain Medical Treatment Guidelines, Section Topical analgesics, pg 112, which is part of MTUS.

Rationale for the Decision:

CA MTUS discusses topical anagesics individually. This requested medication Terocin contains lidocaine and capsaicin. CA MTUS recommends topical lidocaine for neuropathic pain. There is no evidence the employee has neuropathic pain. And even if there was, lidocaine is not a first line therapy. There is no documentation that first line therapy with TCA or AEDs has been tried). Capsaicin is a topical treatment recommended for patients with osteoarthritis, fibromyalgia or chronic back pain. The employee has none of these issues. **The request for Terocin is not medically necessary and appropriate.**

2) Regarding the request for Omeprazole 20mg #60:

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

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section NSAIDS and GI risk, pg 68, which is part of MTUS.

Rationale for the Decision:

CA MTUS is specific for GI prophylaxis. The guides recommend prophylaxis only if the criteria are met. The criteria include: Determine if the patient is at risk for

gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. The employee does not meet criteria for PPI according to records. **The request for Omeprazole 20mg #60 is not medically necessary and appropriate.**

3) Regarding the request for Cyclobenzaprine 7.5mg #60:

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

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Cyclobenzaprine, pg 41, which is part of MTUS.

Rationale for the Decision:

CA MTUS chronic pain guides state that cyclobenzaprine is an option for a short course of therapy. The indications are for chronic pain, usually for low back pain, fibromyalgia and post op care. The employee does not show signs of these issues. There is no clear documentation on how this medication will help the patient. **The request for Cyclobenzaprine 7.5mg #60 is not medically necessary and appropriate.**

4) Regarding the request for Tylenol #3 #60:

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

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

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

Rationale for the Decision:

CA MTUS has clear criteria in regarding the start of opioids. (Criteria for use of opioids). Initial treatment should include first line analgesics. In this case, the employee is starting NSAIDS as they have not been treated since 2/2013. The guidelines clearly state "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics." **The request for Tylenol #3 #60 is not medically necessary and appropriate.**

5) Regarding the request for TENS unit:

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

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Transcutaneous electrotherapy, pg 114, which is part of MTUS.

Rationale for the Decision:

CA MTUS chronic pain guidelines are specific with regards to TENS. It is not recommended as a primary treatment modality. However, they do suggest a one month trial may be used if combined with functional restoration. Criteria for use include: Chronic intractable pain (for the conditions noted above) Documentation of pain of at least three months duration - There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. Other ongoing pain treatment should also be documented during the trial period including medication usage. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. As stated in the criteria, the employee has not met the need for a TENS. The employee is starting medication treatment which they have not had for several months, which should be given a one month trial of TENS first before getting equipment and there needs to be a functional restoration program in place for the trial to be effective. The employee has not had a trial of TENS. **The request for TENS unit is not medically necessary and appropriate.**

6) Regarding the request for 1 wrist splint:

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

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 11, Forearm, Wrist, and Hand Complaints, pgs 264, 265, and 270, which is part of MTUS. The Claims Administrator also based its decision on the Official Disability guidelines, Forearm, Wrist, and Hand (acute and chronic), Splints, which is not part of MTUS.

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) pgs 271-273, Table 11-7, which is part of MTUS.

Rationale for the Decision:

This case has no reference to wrist issues. The employee does not have a displaced fracture, carpal tunnel syndrome or arthritis noted. There is no documented reason for the wrist splint as the employee has an injury to the finger. ACOEM TABLE 11-7 recommends splinting for CTS, deQuervain's strains. There is no documentation of wrist strain. **The request for 1 wrist splint is not medically necessary and appropriate.**

7) Regarding the request for 1 ultrasound:

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

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

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) pgs 265, and the Postsurgical Treatment Guidelines, which are part of the MTUS.

Rationale for the Decision:

CA MTUS refers to ACOEM for hand wrist and forearm. ACOEM discusses ultrasound for the hand in regards to CTS only. CA MTUS post surgical guidelines give ultrasound weak evidence for therapeutic effects in conjunction with hand therapy. **The request for 1 ultrasound is not medically necessary and appropriate.**

8) Regarding the request for 1 paraffin bath:

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

The Claims Administrator based its decision on the Official Disability Guidelines, Forearm, Wrist, and Hand (acute and chronic), which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Paraffin, which is not part of the MTUS.

Rationale for the Decision:

CA MTUS and ACOEM do not address the use of paraffin wax. ODG states that paraffin is useful in arthritis treatment in conjunction with exercise. The employee has no evidence of arthritis. There is no indication given by the provider for paraffin bath as well. There is no indication for paraffin bath given by the provider or guidelines. **The request for paraffin bath 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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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.