

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/20/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	1/11/2009
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0010353

- 1) MAXIMUS Federal Services, Inc. has determined the request for **additional physical therapy 2 times a week for six weeks to the left shoulder is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ultram (Tramadol 50mg) #120 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Diclofenac Flex-Plus 10%/10%/5% (Diclofenac/ Cyclobenzaprine/ Lidocaine) is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Theraflex cream (Flurbiprofen/ Cyclobenzaprine/ Menthol 20%/10%/4% 180g) is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/19/2013. 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 **additional physical therapy 2 times a week for six weeks to the left shoulder** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ultram (Tramadol 50mg) #120** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Diclofenac Flex-Plus 10%/10%/5% (Diclofenac/ Cyclobenzaprine/ Lidocaine)** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Theraflex cream (Flurbiprofen/ Cyclobenzaprine/ Menthol 20%/10%/4% 180g)** 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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular 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 who had a work injury on 1/11/09 when she was working with flower pots on a cart. One of the pots was about to fall off the cart. The patient reached out to prevent this pot from falling and injured her neck, left shoulder and left elbow. She continues to have pain in her left shoulder, elbow and neck. She has had left shoulder arthroscopic surgery on 3/11/13 with a left shoulder subacromial decompression and acromioplasty, physical therapy, cervical steroid injections. She continues to have decreased shoulder range of motion (ROM), positive Neer and Hawkins' signs. The above issues are at dispute regarding additional physical therapy (PT) for the left shoulder is necessary as well as her medications of Ultram, Diclofenac Flex Plus and Theraflex cream.

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 Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for additional physical therapy 2 times a week for six weeks to the left shoulder:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine and CA MTUS-General Approaches-Restoration of Function Chapter, which are a part of the MTUS.

The Expert Reviewer based his/her decision on the Post Surgical Treatment Guidelines, Shoulder, page 28, which is a part of the MTUS.

Rationale for the Decision:

The reviewed medical records indicate the employee has completed 24 sessions of PT with little documentation of functional gains. The records still indicate impingement. The employee has exceeded the postsurgical physical medicine guidelines for arthroscopic shoulder surgery. There are no specific PT notes included which indicate functional improvements. **The request for additional physical therapy 2 times a week for six weeks to the left shoulder is not medically necessary and appropriate.**

2) Regarding the request for Ultram (Tramadol 50mg) #120:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Specific Opioids: Tramadol, pg. 84, which is a part of the MTUS.

Rationale for the Decision:

Per the Chronic Pain MTUS Guidelines regarding Tramadol: There are no long term studies to allow for recommendations for longer than three months (Cepeda, 2006). The records indicate the employee was on Tylenol #3 and changed to Tramadol on 5/30/13. At this point the employee has exceeded the 3 month recommended limit for remaining on Tramadol per the guidelines. **The request for Ultram (Tramadol 50mg) #120 is not medically necessary and appropriate.**

3) Regarding the request for Diclofenac Flex-Plus 10%/10%/5% (Diclofenac/ Cyclobenzaprine/ Lidocaine):

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg. 111-113, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antisposmodics, pg. 64 and Topical Analgesics, pages 111-112, which is a part of the MTUS.

Rationale for the Decision:

According to the Chronic Pain Treatment Guidelines, there is little use to support the use of many of topical analgesics agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Theraflex cream contains Cyclobenzaprine which is recommended for a short course of therapy (see page 64). Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. Limited, mixed-evidence does not allow for a recommendation of chronic use of Cyclobenzaprine. **The request for Diclofenac Flex-Plus 10%/10%/5% (Diclofenac/ Cyclobenzaprine/ Lidocaine), is not medically necessary and appropriate.**

4) Regarding the request for Theraflex cream (Flurbiprofen/ Cyclobenzaprine/ Menthol 20%/10%/4% 180g):

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 Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg 111-113, which is a part of the MTUS and the Official Disability Guidelines (ODG) Pain Chapter: Herbal Medicines, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antisposmodics, pg. 64 and Topical Analgesics, pages 111-112, which is a part of the MTUS.

Rationale for the Decision:

According to the Chronic Pain Treatment Guidelines, there is little use to support the use of many of topical analgesics agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Theraflex cream contains Cyclobenzaprine which is recommended for a short course of therapy (see page 64). Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. Limited, mixed-evidence does not allow for a recommendation of chronic use of Cyclobenzaprine. **The request for Theraflex cream (Flurbiprofen/ Cyclobenzaprine/ Menthol 20%/10%/4% 180g) is not medically necessary and appropriate.**

Effect 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.