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## Independent Medical Review Final Determination Letter

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Dated: 12/18/2013

<b>IMR Case Number:</b>	CM13-0010585	<b>Date of Injury:</b>	9/7/2012
<b>Claims Number:</b>	██████████	<b>UR Denial Date:</b>	8/6/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	8/14/2013
<b>Employee Name:</b>	██████████		
<b>Provider Name:</b>	██████████████████		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>	Please reference utilization review determination letter.		

DEAR ██████████

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, ██████████

## 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 Emergency Medicine and is licensed to practice in New York and Tennessee. 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from (Claims Administrator, employee/employee representative, Provider)
- Medical Treatment Utilization Schedule (MTUS)

### 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 was a 60 year old right hand dominant female who presented for evaluation on September 28, 2012 after an injury dated September 7, 2012. Injury was to the right arm and neck. Mechanism of injury was repetitive positioning her head in awkward positions to observe television screens. The patient was diagnosed with muscle spasm, cervical strain, and strain and sprain to the shoulders and right arm. The patient's injury was treated with physical therapy, Ketorolac, naproxen, acetaminophen, and Ultracet. Cervical spine MRI was completed on 11/16/12 and revealed diffuse disc bulging of 2-3 mm at C4-5 and C6-7 and anterior disc bulging of 2-3 mm at C 5-6. Right shoulder MRI was completed on December 12/28/12 and revealed moderate proliferative changes to the acromioclavicular joint with impingement of the supraspinatus muscle/tendon junction and partial supraspinatus insertion to the humeral head. On June 28, 2013 a claim for treatment with 360 Anaprox 550 mg, 90 Flexeril 10 mg, 60 Ultracet, Terocin 120 ml, and FlurGel 120 gm was submitted.

### IMR DECISION(S) AND RATIONALE(S)

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

#### **1. 360 Anaprox 550 mg is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 22, 60 and 67, which are part of the MTUS.

The Physician Reviewer's decision rationale:

Anaprox is a nonsteroidal anti-inflammatory drug. Chronic Medical Treatment Guidelines state that "anti-inflammatory drugs are the traditional first line of treatment, but long term use may not

be warranted". For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Medications for chronic pain usually provide temporary relief. Medications should be prescribed only one at a time and should show effect within 1-3 days. Record of pain and function with the medication should be recorded. In this case the employee had been receiving the medication for several months without relief. **The request for 360 Anaprox 550 mg is not medically necessary and appropriate.**

## **2. 90 Flexeril 10 mg is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), Cyclobenzaprine and Muscle Relaxants (for pain), which are part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 41-42 and 63, which are part of the MTUS.

The Physician Reviewer's decision rationale:

Chronic Medical Treatment Guidelines state that muscle relaxants should be used with caution as a second-line option only. They may be effective in reducing pain, and muscle tension, and increasing mobility, but have been shown to have little benefit in back pain patients. Flexeril is recommended as an option, for a short course of therapy. It has been found to be more effective than placebo with greater adverse side effects. Its greatest effect is in the first 4 days. Treatment should be brief. In this case, the employee had been treated for 9 months. This is long past the window of effectiveness for the Flexeril. **The request for 90 Flexeril 10 mg is not medically necessary and appropriate.**

## **3. 60 Ultracet is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 76-96, which are part of the MTUS.

The Physician Reviewer's decision rationale:

Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDs have failed. Ultracet (tramadol) is a synthetic opioid affecting the central nervous system. It has several side effects which include increasing the risk of seizure in patients taking SSRI's, TCA's and other opioids. In this case the medication was not prescribed for short term use and the criteria for opioid use were not met. **The request for 60 Ultracet is not medically necessary and appropriate.**

#### **4. Terocin 120 ml is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 28, 105, 111-112, which are part of the MTUS.

The Physician Reviewer's decision rationale:

Terocin is a topical multidrug compound, which contains methylsalicylate, capsaicin, menthol, and Lidocaine. Per Chronic Pain Medical Treatment Guidelines, only one medication should be given at a time and a trial should be given for each individual medication. Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Lidocaine is recommended for localized peripheral pain after the evidence of trial for first-line therapy. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. Capsaicin is recommended only as an option in patients who have not responded or cannot tolerate other treatments. It is recommended for osteoarthritis, fibromyalgia, and chronic non-specific back pain and is considered experimental in high doses. Methylsalicylate is a topical salicylate and is recommended, being significantly better than placebo in chronic pain. There are no guidelines present for menthol. In this case the employee received multidrug compound for medication. This is not consistent with the recommendation for only one medication should be given at a time. Topical Lidocaine is indicated only for post-herpetic neuralgia which is not the diagnosis in this case. The topical compound is not medically necessary in this case. **The request for Terocin 120 ml is not medically necessary and appropriate.**

#### **5. Flur20 gel 120 gm is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Pain Interventions and Treatments

The Physician Reviewer's decision rationale:

The specific ingredients for Flur20 gel are not mentioned and are not available. Novel compounds are not FDA approved. They lack information to allow determination for medical necessity and safety. **The request for Flur20 gel 120 is not medically necessary and appropriate.**

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.

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CM13-0010585