

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/17/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/30/2013
Date of Injury:	9/30/2009
IMR Application Received:	8/13/2013
MAXIMUS Case Number:	CM13-0010736

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Terocin Pain Relief lotion 4 oz is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **60 tablets of Tramadol ER 150 mg is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 7/30/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/20/2013. 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 **Terocin Pain Relief lotion 4 oz** is not **medically necessary and appropriate**.

Medical Qualifications of the Expert Reviewer:

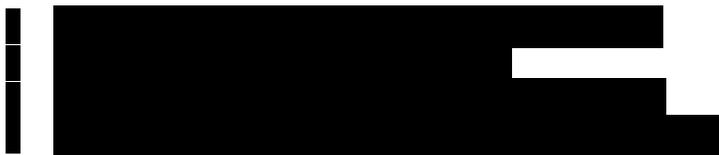
The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. He/she has been in active 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 66-year-old female who is reported to have sustained a cumulative trauma injury to the bilateral hands, wrists and fingers from 01/01/1995 to 07/23/2012. The current diagnoses include status post bilateral carpal tunnel release in 2009 and 2010, status post left thumb CMC interpositional arthroplasty in 2012, persistent bilateral wrist and hand arthralgia, and bilateral De Quervain's. A clinical note dated 06/20/2013 reported the patient continued to complain of bilateral wrist and hand symptoms.. On physical examination, the patient is noted to have left wrist flexion to 50 degree, extension to 50 degrees, radial deviation to 10 degrees, ulnar deviation to 30 degrees. There was a scar at the base of her thumb as well as carpal tunnel per her history. She had positive Tinel's, positive Phalen's, positive carpal compression test, 4/5 grip strength was noted. There was tenderness to palpation at the base of the thumb, positive Finkelstein's, full range of motion of all the MCP and IP joints. There was decreased sensation to light touch over the left superficial sensory branch of the radial nerve. Examination of the right wrist noted flexion of 50 degrees, extension of 50 degrees, radial deviation to 10 degrees, ulnar deviation to 30 degrees, positive Finkelstein's test, positive CMC grind test, positive Tinel's and Phalen's, positive carpal compression test, 4/5 grip strength and full range of motion of the bilateral MCP and IP joints. X-rays performed on 06/20/2013 of the left wrist and hand noted evidence of CMC arthroplasty. X-rays of the right wrist and hand performed on that date noted moderate CMC DJD.

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:



1) Regarding the request for Terocin Pain Relief lotion 4 oz:

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 CA MTUS, (Chapter 11), Forearm, Wrist, and Hand Complaints. The Chronic Pain Medical Treatment Guidelines, Opioids, specific drug list which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-113 which is part of the MTUS.

Rationale for the Decision:

The employee is a 66-year-old female who sustained a repetitive motion injury to the bilateral hands and wrists in 2009 and a cumulative trauma injury from 01/01/1995 to 07/23/2012. The employee is noted to have previously undergone carpal tunnel releases in 2009 and 2010, left thumb (CMC) carpometacarpal interpositional arthroplasty in 2012. The employee is reported to have been found to have persistent bilateral hand and wrist arthralgia and bilateral De Quervain's syndrome. The California MTUS guidelines state that any compound cream that contains 1 drug or drug class is not recommended as use for treatment. They state that topical nonsteroidal anti-inflammatories are recommended for short-term use only, for 4 up to 12 weeks, and lidocaine is not recommended in any formulation other than Lidoderm patches and states that lidocaine is not recommended for non-neuropathic pain. As Terocin pain relief lotion contains Methyl Salicylate 25% and Lidocaine 2.50%, and the employee appears to be utilizing the lotion on a routine, long-term basis, the lotion does not meet guidelines recommendations. **The requested Terocin pain relief lotion 4 oz is neither medically necessary nor appropriate.**

2) Regarding the request for 60 tablets of Tramadol ER 150 mg :

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

The Claims Administrator based their decision on the CA MTUS Forearm, Wrist, and Hand Complaints and the Chronic Pain Medical Treatment Guidelines, Opioids, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-113, which is part of the MTUS.

Rationale for the Decision:

The employee reported a repetitive injury to the bilateral hands, wrists and fingers in 2009 and a cumulative trauma injury from 01/01/1995 to 07/23/2012. The medical records submitted and reviewed indicate the employee is noted to have undergone bilateral carpal tunnel releases, the first in 2009 and second in 2010, and a left thumb CMC interpositional arthroplasty in 2012. The employee was noted to have been diagnosed with persistent wrist and hand arthralgia and bilateral De Quervain's. The records indicate the employee was prescribed tramadol ER 150 mg for 60 tablets and there were continued complaints of ongoing pain of the wrists and hands. The California MTUS Guidelines state that there should be ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects and pain assessment should include the patient's current pain, least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long the pain relief lasts and indicates that satisfactory response to treatment may be indicated by decreased pain, increased level of function or improved quality of life. There is no documentation that the employee received pain relief with the use of tramadol or had improved functional status. Additionally, the medical records do not document that there has been an evaluation for appropriate medication use or side effects. **The request for 60 tablets of tramadol ER 150 mg 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

/cm

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.