

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/7/2013
Date of Injury: 8/9/2010
IMR Application Received: 8/16/2013
MAXIMUS Case Number: CM13-0011063

DEAR [REDACTED]

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, [REDACTED]
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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 physical medicine and rehabilitation, has a subspecialty in sports medicine and is licensed to practice in New York and Texas. 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:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

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 is a 52-year-old who reported a work-related injury on 08/09/2010 as a result of strain to the bilateral upper extremities. Subsequently, the patient presents for treatment of the following diagnoses: (1) status post arthroscopic surgery right shoulder; (2) status post arthroscopic surgery left shoulder; (3) right elbow medial epicondylitis; (4) left elbow sprain; (5) right wrist sprain; (6) left wrist sprain; (7) right hand sprain; (8) left hand no abnormalities. The clinical note dated 07/31/2013 reports the patient was seen under the care of Dr. [REDACTED]. The provider documents the patient presents with continued complaints of left elbow pain. The patient reports pain to her left elbow and would like a cortisone injection, bilateral wrist braces, and a left tennis elbow brace. The provider documented upon physical exam of the patient, left elbow was tender upon palpation over the lateral epicondyle; the patient's elbow range of motion was 130 degrees flexion and 0 degrees extension. The provider recommended the following: bilateral Quick-Fit wrist brace and left tennis elbow brace, administration of a cortisone injection to the left elbow, and topical analgesics.

IMR DECISION(S) AND RATIONALE(S)

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

1. Bilateral quick fit wrist brace is not medically necessary and appropriate.

The Claims Administrator based its decision on the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10), page 26, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), page 264 (online edition), which is part of the MTUS.

The Physician Reviewer's decision rationale: According to the Forearm, Wrist, and Hand Complaints Chapter of the ACOEM Practice Guidelines, Initial treatment of carpal tunnel syndrome should include night splints. Day splints can be considered for employee comfort as needed to reduce pain along with work modifications. The current request previously received an adverse determination due to lack of documentation of any significant subjective, objective, or diagnostic indication of wrist complaints or lack of wrist function. Additionally, the employee is over 3 years status post reporting a work-related injury with documented diagnoses of bilateral carpal tunnel syndrome. The clinical notes do not evidence of the employee has previously utilized splinting to the bilateral wrists and the efficacy of such treatment. The clinical notes lacked documentation of a recent physical exam of the employee's bilateral wrists to evidence any objective functional deficits or documentation of the employee's subjective complaints of pain to support the requested DME (durable medical equipment). **The request for bilateral quick fit wrist brace is not medically necessary or appropriate.**

2. Prescription Theraflux Ultra cream 180gm is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale: According to the Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. As a topical analgesic contains flurbiprofen, cyclobenzaprine, and tramadol, the requested topical analgesic is not supported. The Chronic Pain Medical Treatment Guidelines additionally indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The Chronic Pain Medical Treatment Guidelines indicates regarding muscle relaxants utilized in topical analgesics, as there is no evidence for use of any other muscle relaxant as a topical product. **The request for Error! Reference source not found. is not medically necessary or appropriate.**

3. Prescription of Bio-Therm pain relieving lotion, 4 oz, is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale: According to the Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. As a topical analgesic contains flurbiprofen, cyclobenzaprine, and tramadol, the requested topical analgesic is not supported. The Chronic Pain Medical Treatment Guidelines additionally indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. **The request for Error! Reference source not found. is not medically necessary or appropriate.**

4. Prescription Theraflux Ultra cream 30gm is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale: According to the Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. As a topical analgesic contains flurbiprofen, cyclobenzaprine, and tramadol, the requested topical analgesic is not supported. The Chronic Pain Medical Treatment Guidelines additionally indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The Chronic Pain Medical Treatment Guidelines indicates regarding muscle relaxants utilized in topical analgesics, There is no evidence for use of any other muscle relaxant as a topical product. **The request for Error! Reference source not found. is not medically necessary or 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.

[REDACTED]

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