

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/2/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/16/2013
Date of Injury: 10/5/1999
IMR Application Received: 8/15/2013
MAXIMUS Case Number: CM13-0011622

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Medrox patches #1 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one interlaminar epidural steroid injection at C5-6 with catheter placement C7-T1 is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **six (6) physical therapy sessions is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 7/16/2013. 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 **Medrox patches #1** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one interlaminar epidural steroid injection at C5-6 with catheter placement C7-T1** is **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **six (6) physical therapy sessions** is **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:

Claimant is a 47 year old male with date of injury 10/5/1999 to 12/31/2004. Diagnoses include herniated nucleus pulposus C6-7, bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, degenerative disc disease with retrolisthesis C3-4 and C4-5, status post bilateral knee surgery, status post left elbow surgery, and status post right shoulder surgery. Progress note dated 6/13/2013 reports that claimant has pain 3-5/10. Arm complaints are worse with more difficulty with activities. Twelve sessions of physical therapy following his knee surgery has helped minimally. Terocin cream and Medrox patches are reportedly effective in controlling pain and allowing for an increased level of function.

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 Medrox patches #1:

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, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical analgesics, pgs. 28, 105, 111, which are part of the MTUS.

Rationale for the Decision:

The clinical notes provided for review do not provide any information in regards to support the use of Medrox patches for this employee. There is no mention of intolerance to other treatments, nor any mention of failure of other treatments. Medrox is a combination medication that would require justification of the use of each agent. The clinical notes provided do not support the use of Medrox as described in these guidelines. **The request for Medrox patches #1 is not medically necessary and appropriate.**

2) Regarding the request for one interlaminar epidural steroid injection at C5-6 with catheter placement C7-T1:

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, Epidural steroid injection, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Epidural steroid injection, pg. 46, which is part of the MTUS.

Rationale for the Decision:

The employee currently has pain rated at 3-5/10 and has demonstrated adequate response to conservative therapy for the upper extremity and cervical spine pain. There are physical exam findings to support the diagnosis of sensory radiculopathy, but EMG studies and imaging studies that have been performed are not corroborative for the diagnosis of C5-6 root pathology. **The request for one interlaminar epidural steroid injection at C5-6 with catheter placement C7-T1 is not medically necessary and appropriate.**

3) Regarding the request for six (6) physical therapy sessions:

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, Physical medicine, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical medicine, pgs. 98-99, which are part of the MTUS.

Rationale for the Decision:

The employee has had at least 12 sessions of physical therapy, and reported minimal benefit. Following 12 sessions of physical therapy, the employee should be adequately prepared to continue self-directed home therapy. **The request for six (6) physical therapy sessions 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

/ldh

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.