

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/26/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/17/2013
Date of Injury: 3/12/2012
IMR Application Received: 8/15/2013
MAXIMUS Case Number: CM13-0011715

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]

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 Internal 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 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 claimant is a 44-year-old female who was injured on 03/12/2012. The clinical progress report of 05/28/2013 gives a chief complaint of cervical pain, chronic headaches, shoulder blade tension. It states conservative care including activity modification, physical therapy, and pain management as well as epidural injections to the cervical spine had been utilized. It states the claimant notes compliance with medication with the exception of Naprosyn that caused an "upset stomach." Physical examination showed cervical spine tenderness and paravertebral spasm. There was generalized weakness and numbness in what was described as a C5-6 and C7 nerve root distribution. There were also bilateral upper extremities "consistent with carpal tunnel syndrome." The left shoulder examination was unchanged with tenderness over the subacromial space and positive impingement and Hawkins testing. Her lumbar spine also is with tenderness over the paravertebral musculature with spasm. Current diagnosis was cervical discopathy, lumbar discopathy, carpal tunnel syndrome/double crush syndrome, left shoulder impingement, and bilateral cubital tunnel/lateral epicondylitis. Injections of Toradol were given at that date as well as B12 complex. Recommendations were for continuation of medication management to include Naprosyn, Cyclobenzaprine, Sumatriptan, Ondansetron, Omeprazole, Medrox ointment, and trazodone. The last clinical record for review was a progress report dated 07/12/2013 which was a consultation with [REDACTED], MD, specifically for diagnosis of impingement syndrome and tendinopathy to the rotator cuff citing failed conservative care including corticosteroid injections, anti-inflammatories, and physical therapy. Surgical process in the form of decompression and rotator cuff repair was recommended.

IMR DECISION(S) AND RATIONALE(S)

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

1. 120 capsules of Omeprazole 20mg PRN is not medically necessary and appropriate.

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDS, GI symptoms, Cardiovascular Risk, pgs. 68-69, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS Chronic Pain Medical Treatment Guidelines, Omeprazole in this case would not be supported. Guidelines indicate that the role of proton pump inhibitors are indicated for patients that are at an intermittent risk of gastroesophageal events and no cardiovascular disease. Risk factors would include: (1) an age greater than 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concordant use of aspirin, corticosteroids or anticoagulants; or (4) high dose multiple NSAID usage. A review of the records indicates that while the employee's previous office notes indicated a developed "upset stomach" but did not develop a significant risk factor for gastroesophageal event. A subjective complaint of an upset stomach does not qualify as a diagnosis of peptic ulcer disease, GI bleeding, or perforation, nor does the employee meet any other criteria to be put at high risk of gastroesophageal event. The need for protective proton pump inhibitor in this case, for a employee that appears to be selectively using nonsteroidals on an as needed basis would not be indicated.

2. 60 tablets of Ondansetron 8mg PRN is not medically necessary and appropriate.

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Expert Reviewer found that no section of the MTUS was applicable.

Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on The Official Disability Guidelines, Pain Chapter, Ondansetron, which is not part of MTUS

The Physician Reviewer's decision rationale:

Evidence based criteria including California MTUS/ACOEM Guidelines do not address. Official Disability Guidelines state Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. There is no documentation of prior nausea or vomiting symptoms related to the claimant's current work injury or medications being used for that injury. Therefore, given the lack of nausea and vomiting symptoms of the patient and lack of support of this medication by Official Disability Guidelines, the request for 60 tablets of Ondansetron 8mg PRN is not medically necessary .

3. 120 tablets of Cyclobenzaprine Hydrochloride 7.5mg, 1 tablet every 8 hrs. is not medically necessary and appropriate.

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, cyclobenzaprine, pgs. 41-42, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS Chronic Pain Medical Treatment Guidelines, cyclobenzaprine would not be supported. Cyclobenzaprine and muscle relaxants are not indicated for chronic pain relief as a preferred option. While the role of these agents are beneficial in the first 2 to 3 weeks of acute spasm, their long-term efficacy as well as a high incidence of dependence rate and diminished efficacy over time would not support their use at present. Guidelines indicate no more than short-term use for acute exacerbations of no more than 4 weeks. A review of the records indicates that the employee has clearly been on this agent for a substantial amount of time. Its continued role in treatment of current diagnosis would not be indicated.

4. 240gm of Medrox Pain relief Ointment 120 gm X 2 for 4 times daily is not medically necessary and appropriate.

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, topical analgesics, pgs. 111-113, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS Chronic Pain Medical Treatment Guidelines, role of the topical agent, Medrox ointment would not be supported. Medrox ointment is a combination topical that contains capsaicin, menthol and methyl salicylate. California MTUS Chronic Pain Medical Treatment Guidelines indicate that if any agent in a topical compound is not indicated, the agent as a whole is not indicated. In this case, the role of capsaicin would not be indicated. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other forms of first line treatment. There is no indication of intolerance to other forms of treatment in this case. A review of the records indicates that a continued role of this topical compound based on the above as well as lack of documentation of substantial benefit that would be noted by an improvement in VAS score, diminished objective findings or documentation of advancement of activities such as work function, the need for continued use of the topical compounded agent would not be indicated.

5. 90 tablets of Tramadol Hydrochloride ER 150mg, once per day PRN is not medically necessary and appropriate.

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, tramadol, pg. 93-94, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS Chronic Pain Medical Treatment Guidelines, continued role of tramadol would not be supported. Recent studies in regards to use of tramadol, a non-opioid analgesic, fail to demonstrate its significant benefits beyond a 3 month period of time. There are no long-term studies to allow for recommendations of the drug longer than 3 months. As stated above, a review of the records indicates that there is no documentation of advancement or benefit with use of the prescribed medications at present in relationship to the employee's subjective complaints, objective findings or demonstration of advancement of benefit from an activity point of view. The continued long-term of tramadol at this stage in employee's clinical course would not be indicated.

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]
[REDACTED]
[REDACTED]