

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/28/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/22/2013
Date of Injury: 4/12/2012
IMR Application Received: 8/16/2013
MAXIMUS Case Number: CM13-0012192

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: PARTIAL OVERTURN. This means we decided that some (but not all) 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 Pain Management and Rehabilitation, has a subspecialty in Interventional Spine, 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 IMR application shows an injury date of 4/12/12 and that the patient disputes the 7/22/13 UR decision. The 7/22/13 UR letter is from [REDACTED] and denies, PT, a follow-up evaluation, the use of topical Terocin, Flurbi cream, Somnicin cream and Laxacin cream that were requested on a 7/8/13 report from Dr. [REDACTED]. Unfortunately, this 7/8/13 report was not provided for this IMR. The records provided appear to cover 3-4 different industrial injury dates. As far as I can tell, this is a 61 YO, RHD, 5'10.5", approx. 197 lbs, male who works for the [REDACTED] and on 4/12/12 injured his right shoulder from overhead lifting. He was found to have torn the supraspinatus with 12 mm retraction, and underwent surgical repair on 12/10/12 with Dr [REDACTED]. There apparently was low back injury on 8/4/11 when he was pushing a wheeled bin of trash. There is a report of a 4/3/99 injury involving right foot, and fusion of a MTP joint. The 7/8/13 report was not available for this review, but I do have the 6/5/13 PR2 by Dr. [REDACTED]. It has an error on the date of injury, stated it was 4/12/12, but the report pertains to the lower back. The sole diagnosis is L/S radiculopathy, and the requests are for follow-up with a spinal surgeon, and for the topical compounds gabacyclotram, laxacin, somnicin, terocin, flurbi cream. There was no mention of PT on the 6/5/13 report.

IMR DECISION(S) AND RATIONALE(S)

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

1. 8 Physical Therapy sessions is medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Physical Medicine, pgs. 98-99, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain guidelines recommend 8-10 PT visits for various myalgias or neuralgias. According to the medical records provided for review, the employee had a right shoulder surgery on 12/10/12 and would be out of the 6-month MTUS postsurgical physical medicine treatment timeframe. The Chronic Pain guidelines indicate that physical therapy in the postsurgical physical medicine treatment timeframe does not count towards the Labor Code 24-visit limitation. The request for 8 PT sessions appears to be in accordance with the MTUS Chronic Pain guidelines. **The request for 8 Physical Therapy sessions is medically necessary and appropriate.**

2. 1 Follow-up with a specialist is medically necessary and appropriate.

The Claims Administrator based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), pg 207, which is part of MTUS.

The Physician 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 Physician Reviewer based his/her decision on the ACOEM Practice Guidelines, Chapter 7, pg. 127, which is not part of MTUS.

The Physician Reviewer's decision rationale:

It is not clear what specialist is requesting the follow-up with, because no documentation were submitted for review for 7/8/13. From the 6/5/13 report, the provider was requesting the follow-up to be with a spinal surgeon for the low back injury. The consultation could also be with the shoulder surgeon. Either way, ACOEM supports referral to "other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." **The request for 1 follow-up with a specialist is medically necessary and appropriate.**

3. One prescription of Terocin topical cream is not medically necessary and appropriate.

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

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

The Physician Reviewer's decision rationale:

Terocin is a compounded topical pain medication with methyl salicylate, capsaicin, menthol and Lidocaine. The Chronic Pain guidelines indicate that these are recommended after failure of antidepressants or anticonvulsants and they state "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Terocin contains topical lidocaine. The Chronic Pain guidelines specifically indicate, other than the dermal patch, other formulations of lidocaine whether creams, lotions or gels are not approved for neuropathic pain. So a compounded topical cream that contains Lidocaine would not be recommended by MTUS Chronic Pain guideline criteria. **The request of Terocin topical cream is not medically necessary and appropriate.**

4. One prescription of Flurbi topical cream is not medically necessary and appropriate.

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

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

The Physician Reviewer's decision rationale:

Flurbi cream appears to be a topical NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) with Flurbiprofen. The accepted body part for this claim is the right shoulder, and the other work-injury is to the lower back. The MTUS Chronic Pain guidelines for topical NSAIDs indicate that this class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). The MTUS Chronic Pain guidelines specifically indicate that "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." The request is not in accordance with MTUS Chronic Pain guidelines. **The request for one prescription of Flurbi topical cream is not medically necessary and appropriate.**

5. One prescription for Somnicin topical cream is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence-based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Topical Analgesics, pgs. 111-113, which is part of MTUS; and, the Official Disability Guidelines (ODG), Pain Chapter, Vitamin B, which is not part of MTUS.

The Physician Reviewer's decision rationale:

Somnicin is apparently a compound of melatonin, 5-THP, L-tryptophan, vitamin B6 and magnesium. The MTUS Chronic Pain guidelines indicate that if a compound medication contains a component or drug class that is not recommended, then the whole compound is not recommended. Somnicin contains vitamin B6. The MTUS Chronic Pain guidelines do not discuss vitamin B6, but the ODG guidelines, Pain Chapter online, under Vitamin B, indicates that it is "not recommended". Since one component of the compound Somnicin is not recommended, the whole compound is not recommended. **The request for one prescription for Somnicin topical cream is not medically necessary and appropriate.**

6. One prescription for Laxacin topical cream is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence-based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Pain Outcomes and Endpoints, pgs. 8-9, which is part of MTUS.

The Physician Reviewer's decision rationale:

The submitted records for review does not provide a description or rationale for Laxacin. There is no report of constipation, no mention of the use of any narcotic pain medication that may have caused constipation. The MTUS Chronic Pain guidelines indicate that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain, and assessment of treatment efficacy is accomplished by reporting functional improvement. There is no documentation that the Laxacin helps with any functional status. The request is inconsistent with the MTUS guidelines. **The request for Laxacin topical cream is not medically necessary and appropriate.**

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[REDACTED]

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