

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/24/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/9/2013
Date of Injury: 6/2/1997
IMR Application Received: 8/19/2013
MAXIMUS Case Number: CM13-0013664

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 Orthopedic Surgery 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from (Claims Administrator)
- Medical Treatment Utilization Schedule (MTUS)

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 47-year-old female who reported an injury on 06/02/1997. The patient is currently diagnosed with status post bilateral carpal tunnel releases with residual, bilateral cubital tunnel syndrome, chronic right lateral epicondylitis, status post bilateral middle trigger finger releases, and bilateral shoulder impingement syndrome. The patient was most recently evaluated by Dr. [REDACTED] on 07/30/2013. Objective findings included full range of motion of the right shoulder with slight pain, intact strength, slight tenderness over the lateral epicondyle and extensor muscle mass of the right elbow with increased pain with resisted wrist extension. Treatment plan included continuation of current medications.

IMR DECISION(S) AND RATIONALE(S)

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

1. Dendracin lotion 120ml is not medically necessary and appropriate.

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

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

The Physician Reviewer's decision rationale:

The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended as a whole. As per the clinical notes submitted, there is no evidence of a trial of oral antidepressants and anticonvulsants prior to the request for topical

analgesic. Benzocaine is comparable to Lidocaine, which is indicated for neuropathic pain and localized peripheral pain. Based on the clinical information received and the California MTUS Guidelines, the request cannot be determined as medically appropriate and is non-certified at this time.

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]