
Notice of Independent Medical Review Determination

Dated: 12/17/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/20/2013
Date of Injury: 4/11/2004
IMR Application Received: 9/3/2013
MAXIMUS Case Number: CM13-0019553

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Pennsaid drops is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Twelve chiropractic manipulations is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Lidoderm patches is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Phenergan is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Flector patches is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 9/3/2013 disputing the Utilization Review Denial dated 8/20/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **Pennsaid drops is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Twelve chiropractic manipulations is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Lidoderm patches is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Phenergan is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Flector patches is not 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 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 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:

The patient is a 40-year-old female who reported an injury on 04/11/2004. The mechanism of injury was not specifically stated. Current diagnoses for this patient include chronic, diffuse right shoulder region pain; chronic right scapular pain; chronic low back pain; right shoulder degenerative joint disease; status post multiple surgeries, including humeral head implant followed by revision surgery; poor healing surgical wound along the right anterior shoulder; right cervical radicular pain; right posterior knee pain; right upper extremity pain; chronic right cervical radiculitis; and degenerative C4-5 disc as well as regional Myofascial pain involving the right shoulder girdle musculature. The patient was most recently seen by Dr. [REDACTED] on 08/12/2013 for complaints of right shoulder and arm pain as well as low back and posterior neck pain. Physical examination revealed tenderness and tightness in the right posterior cervical area diffuse tenderness and tightness across the lumbosacral area, lesions of a right shoulder anterior surgical scar, and moderate sanguineous drainage from 2 small wounds, painful range of motion and normal sensation and deep tendon reflexes. Recommendations included continuation of current medications, continuation of all

conservative measures including ice, heat, rest and exercise and an authorization request for an epidural steroid injection to the lumbar and cervical spine.

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 Treatment Utilization Schedule (MTUS)
- Medical Records from Claims Administrator

1) Regarding the request for Pennsaid drops:

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 NSAIDs, which is part of the MTUS.

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

Rationale for the Decision:

The California MTUS Guidelines state that topical NSAIDs may be useful for chronic musculoskeletal pain; however, there are no long-term studies of their effectiveness or safety. There is little evidence to support the use of topical NSAIDs for the treatment of osteoarthritis of the spine, hip or shoulder; and this class of medications is not recommended topically for the management of neuropathic pain as there is no evidence to support its use. The employee does not currently meet criteria as outlined above. The employee also suffers from a persistent open wound, which would contraindicate the use of topical medications. Based on the clinical information received and the California MTUS Guidelines, the request for Pennsaid is non-certified. **The request for Pennsaid drops is not medically necessary and appropriate.**

2) Regarding the request for Twelve chiropractic manipulations:

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 (2009), Chiropractic Treatment, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009) p. 58, Manual Therapy and Manipulation, which is part of the MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Treatment for the low back is recommended as an option with a trial of six visits over two weeks. With evidence of objective functional improvement, a total of up to 18 visits over six to eight weeks may be warranted. Based on the clinical information received, the employee has undergone chiropractic treatment in the past. However, the employee's objective findings remained unchanged, and there was no documentation of specific functional improvement. Without documentation of exceptional factors or significant improvement, the ongoing use of manual therapy cannot be determined as medically necessary. **The request for Twelve chiropractic manipulations is not medically necessary and appropriate.**

3) Regarding the request for Lidoderm patches:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pg. 112, which is part of MTUS

Rationale for the Decision:

The California MTUS Guidelines state that Lidocaine is recommended for neuropathic pain. It is also recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy with antidepressants and anticonvulsants. Topical Lidocaine in the form of a dermal patch has been designated by the FDA for neuropathic pain. It is not recommended for non-neuropathic pain. A previous utilization review was conducted on 08/21/2013, and additional information was requested to clarify the subjective and objective functional response to the previous use of Lidoderm patches. The requested information has not been received; therefore, the request cannot be determined as medically appropriate at this time. **The request for Lidoderm patches is not medically necessary and appropriate.**

4) Regarding the request for Phenergan:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

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 (ODG), Chronic Pain Chapter Online Edition, which is part of MTUS.

Rationale for the Decision:

The Official Disability Guidelines state that anti-emetics for opioid nausea are not recommended. Phenergan is recommended as a sedative and anti-emetic in pre-operative and postoperative situations. Nausea and vomiting are common with the use of opioids. These side effects tend to diminish over days to weeks of continued exposure. Again, a previous utilization review report was conducted on 08/21/2013, and additional information was requested to clarify the subjective and functional response to the previous use of Phenergan. As guidelines do not recommend the use of anti-emetics, the current request for the ongoing use cannot be determined as medically appropriate. **The request for Phenergan is not medically necessary and appropriate.**

5) Regarding the request for Flector patches:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination..

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical NSAIDs, which is part of MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that topical NSAIDs may be useful for chronic musculoskeletal pain; however, there are no long-term studies of their effectiveness or safety. They are primarily recommended for neuropathic pain when trials of anticonvulsants and antidepressants have failed. Topical NSAIDs have been shown to be superior to placebo during the first two weeks of treatment for osteoarthritis with a diminishing effect over another two week period. Indications for a topical NSAID include osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use of up to four to twelve weeks. Additional information was previously requested to clarify the subjective and functional response to the previous use of Flector patches and to also clarify the dose and frequency of administration. As per the latest physician examination on 08/12/2013, Flector patches were not listed under the employee's current medication list, nor were they recommended for continued use during the documented treatment plan. Based on the clinical information received and the California MTUS Guidelines, the ongoing use of this medication cannot be determined as medically appropriate. **The request for Flector patches 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

/cmol

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]