MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 9/9/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/2/2013
Date of Injury:	11/17/2010
IMR Application Received:	7/16/2013
MAXIMUS Case Number:	CM13-0001635

1) MAXIMUS Federal Services, Inc. has determined the request for omeprazole (Prilosec) 20mg #30 plus one (1) refill **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for Hydrocodone/APAP (Norco) 10/325mg #90 plus one (1) refill **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for cyclobenzaprine compound transdermal cream 60gms plus one (1) refill **is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm 240ml base for topical cream **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/18/2013. 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 omeprazole (Prilosec) 20mg #30 plus one (1) refill **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for Hydrocodone/APAP (Norco) 10/325mg #90 plus one (1) refill **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for cyclobenzaprine compound transdermal cream 60gms plus one (1) refill **is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm 240ml base for topical cream **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 Physical Medicine and Rehabilitation 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.

Case Summary:
Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 2, 2013

"CLINICAL SUMMARY: [redacted] is a 39 year old (DOB: 04/24n4) with a date of injury on 11117/10. Right carpal tunnel syndrome, stono~ing tenosynovitis right thumb; wrist sprain."

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 for Independent Medical Review (received 7/16/13)
- Utilizaton Review Determination (dated 7/2/13)
- Employee medical records from [redacted] (dated 3/19/13)
- Employee medical records from [redacted] (dated 3/14/13)

- Medical records from [redacted] MD (dated 7/24/12-6/24/13)
- Chronic Pain Medical Treatment Guidelines – Division of Workers' Compensation and Official Disability Guidelines References (May, 2009)

1) **Regarding the request for omeprazole (Prilosec) 20mg #30 plus one (1) refill:**

Medical Treatment Guideline(s) 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), pg. 68-69 which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:
The employee sustained an industrial injury on 11/17/2010. The medical records provided for review indicate diagnoses of right lateral epicondylitis, deQuervain's, ulnar neuritis at cubital tunnel and Guyon tunnel, right carpal tunnel syndrome status post right carpal tunnel release and A1 pulley, right thumb release. The medical record of 5/14/2013 indicate treatment has included trigger point injections and oral and topical medications. The request is for omeprazole (Prilosec) 20mg #30 plus one (1) refill.

MTUS Chronic Pain guidelines indicate a proton pump inhibitor (omeprazole) is recommended for those taking NSAIDs who are experiencing or who are at risk for gastrointestinal events. The medical records provided for review do not document any of the necessary guideline criteria for omeprazole. The request for omeprazole (Prilosec) 20mg #30 plus one (1) refill is not medically necessary and appropriate.

2) **Regarding the request for Hydrocodone/APAP (Norco) 10/325mg #90 plus one (1) refill:**

Medical Treatment Guideline(s) 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), pg 80-81, which is part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:
The employee sustained an industrial injury on 11/17/2010. The medical records provided for review indicate diagnoses of right lateral epicondylitis, deQuervain's,

ulnar neuritis at cubital tunnel and Guyon tunnel, right carpal tunnel syndrome status post right carpal tunnel release and A1 pulley, right thumb release. The medical record of 5/14/2013 indicate treatment has included trigger point injections and oral and topical medications. The request is for hydrocodone/APAP (Norco) 10/325mg #90 plus one (1) refill.

MTUS Chronic Pain guidelines indicate that continued use of opioids is dependent on documentation of functional improvement for quality of living based on the continued use. The medical records provided for review indicate the use of hydrocodone since 7/24/12, however there is no documentation of functional improvement or the improvement in the quality of life. The drug screen from 2/12/13 and 4/30/13 both showed negative for hydrocodone. The request for hydrocodone/APAP (Norco) 10/325mg #90 plus one (1) refill is not medically necessary and appropriate.

3) **Regarding the request for cyclobenzaprine compound transdermal cream 60gms plus one (1) refill:**

Medical Treatment Guideline(s) 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) pg. 111-113, which is part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:
The employee sustained an industrial injury on 11/17/2010. The medical records provided for review indicate diagnoses of right lateral epicondylitis, deQuervain's, ulnar neuritis at cubital tunnel and Guyon tunnel, right carpal tunnel syndrome status post right carpal tunnel release and A1 pulley, right thumb release. The medical record of 5/14/2013 indicate treatment has included trigger point injections and oral and topical medications. The request is for cyclobenzaprine compound transdermal cream 60gms plus one (1) refill.

MTUS Chronic Pain guidelines indicate there is no evidence for the use of a muscle relaxant (cyclobenzaprine) as a topical compound. The request for cyclobenzaprine compound transdermal cream 60gms plus one (1) refill is not medically necessary and appropriate.

4) **Regarding the request for Lidoderm 240ml base for topical cream:**

Medical Treatment Guideline(s) 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) pg. 56-57, 112, which is part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The

Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained an industrial injury on 11/17/2010. The medical records provided for review indicate diagnoses of right lateral epicondylitis, deQuervain's, ulnar neuritis at cubital tunnel and Guyon tunnel, right carpal tunnel syndrome status post right carpal tunnel release and A1 pulley, right thumb release. The medical record of 5/14/2013 indicate treatment has included trigger point injections and oral and topical medications. The request is for Lidoderm 240ml base for topical cream.

MTUS Chronic Pain guidelines indicate topical lidocaine in the form of a dermal patch is recommended by the FDA for neuropathic pain. The guidelines also state "No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." The 240ml "Lidoderm" requested is not the "dermal patch" Lidoderm, but is intended as a base for topical cream. The request for Lidoderm 240ml base for topical cream 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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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.