
Notice of Independent Medical Review Determination

Dated: 9/25/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]
7/16/2013

5/4/2010

7/17/2013

CM13-0001847

- 1) MAXIMUS Federal Services, Inc. has determined the requested an Ortho consult for left shoulder **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Pain Management consult for L/S **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the requested Medrox Patch #10 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the requested Terocin lotion 240 ml **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/17/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 requested an Ortho consult for left shoulder **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Pain Management consult for L/S **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the requested Medrox Patch #10 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the requested Terocin lotion 240 ml **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 16, 2013:

“According to the clinical documentation, the patient is a 36-year-old who sustained an injury on 05/04/10. The mechanism of injury was not documented in the clinical reports submitted with this request. PR-2 dated 06/27/13 by [REDACTED] MD documented that the patient complained of painful lower back, upper back, left hip, and left shoulder which were not any better. On examination, there was pain, tenderness and swelling; and no redness or ecchymosis. Examination of the cervical spine documented flexion at 40/60 degrees; extension at 40/50 degrees; left and right rotation at 70/80 degrees; and left flexion at 10/40 degrees and right flexion at 10/40 degrees. Lumbar spine examination documented flexion at 40/90 degrees; extension at 10/30 degrees; left and right rotation at 10/30 degrees; and rotation at 10/30 degrees bilaterally. Ranges of motion of the left shoulder documented abduction at 110/170 degrees; flexion at 110/160 degrees; internal rotation at 70/70 degrees; external rotation at 20/90 degrees.; extension at 10/30 degrees; adduction at 10/30 degrees; Jamar test on the right was 10/10/10; and 0/0/0 on the left. Pinch test was 1/1/1 on the right and 0/0/0 on the left. There was pain and spasms of the left shoulder with decreased range of motion. The patient obtained 50-60% improvement of neuropathic pain in the left upper extremity

after completion of stellate ganglion block. The dates of the injections were not documented in the clinical reports submitted with this request. It was noted that the patient had minimal pain with light touch on palpation to the left upper extremity and no evidence of claw hand as previously noted prior to the injections. The patient had significantly increased temperature to the left upper extremity. The patient was recommended with physical therapy two times a week for six weeks for desensitization therapy of left upper extremity secondary to chronic regional pain syndrome (CRPS); and continued on current pain medications as prescribed to assist in pain control. The patient was advised that if effectiveness of blocks were short in duration, the next treatment option was cervical spinal cord stimulator trial. Other treatment considerations included addressing left shoulder pain with orthopedist, if surgery as indicated; and stellate ganglion before and after surgery to minimize risk of CRPS. The patient was prescribed with Medrox patch box as needed, #10; and Terocin lotion as needed 240 ml. Pain management consultation with [REDACTED] MD for the lumbar spine was requested. Magnetic Resonance Imaging (MRI) of the lumbar spine dated 07/30/12 interpreted by Dr. [REDACTED] documented the following impressions: degenerative disk disease with L5-S1 left paracentral protrusion and retrolisthesis without evidence for canal stenosis or neural foraminal narrowing at any level. Procedure reports dated 08/24/11 and 01/04/12 documented that the patient had lumbar/ sacroiliac joint injection; procedure report dated 04/06/11 documented that the patient had lumbar/sacral radiofrequency facet joint nerve at left L4-5; and procedure report dated 11/17/10 documented that the patient had lumbar facet medial branch block, left L5-S 1. Electromyography/Nerve Conduction Velocity (EMG/NCV) studies of the lower extremities dated 06/21/12 interpreted by [REDACTED], MD documented the following impressions: normal study; there was no electrodiagnostic evidence of focal nerve entrapment, lumbar radiculopathy or generalized peripheral neuropathy affecting the lower limbs; and please note that radiculopathies that are "irritative" or sensory in nature; and do not cause significant axonal degeneration, may not be detected by either EMG or nerve conduction studies; therefore a "normal" electromyography or nerve conduction study does not rule out radiculopathy. According to the nurse case summary, patient's previous treatments included nerve blocks/injections, narcotic pain medication, physical therapy, transcutaneous electrical nerve stimulation, and acupuncture. The patient was diagnosed with sprain and strain of the cervical spine; sprain and strain of the left hip; strain and sprain of the left shoulder; contusion of the left hip; muscle spasms; and myalgia/myositis. This is a request for the medical necessity for orthopedic consult for left shoulder; pain management consultation for lumbar spine; Medrox patch #10; and Terocin lotion 240ml."

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 (dated 7/17/2013)
- Utilization Review from [REDACTED] (dated 7/16/2013)
- Medical Records from [REDACTED] (dated 7/11/12-5/17/13)
- Medical Records from [REDACTED] (dated 7/11/13-7/15/13)
- Medical Records from [REDACTED] MD (dated 7/16/12-7/15/13)
- Medical Records from [REDACTED] (dated 7/30/12)
- Medical Records from [REDACTED] (dated 10/24/12-6/19/13)

- Medical Records from [REDACTED] (dated 12/3/12-5/30/13)
- Medical Records from [REDACTED], MD (dated 12/18/12)
- Medical Records from [REDACTED] (dated 10/24/12-6/19/13)
- Medical Records from [REDACTED] (dated 1/14/13)
- Medical Records from [REDACTED] (dated 1/14/13)
- Medical Records from [REDACTED] (dated 3/28/13-7/16/13)
- Medical Records from [REDACTED] (4/23/13-6/26/13)
- Medical Records from my [REDACTED] (dated 4/23/13)
- Medical Records from [REDACTED] (dated 5/24/13)
- Medical Records from Dr. [REDACTED] (dated 6/26/13-6/27/13)
- Chronic Pain Medical Treatment Guidelines (May, 2009), Part 1, Introduction pgs. 111-113

1) Regarding the request for an Orthopedic consult for left shoulder:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004), Chapter 7, pg. 127, which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), which is part of MTUS, and the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004), Chapter 7, pg. 127, which is not part of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on May 4, 2010 to the left shoulder, left hip, upper and lower back. Medical records provided for review indicate treatments have included nerve blocks/injections, narcotic pain medication, physical therapy, transcutaneous electrical nerve stimulation, and acupuncture. The request is for an orthopedic consult for the left shoulder.

ACOEM guidelines state “The occupational health practitioner may refer 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 medical records provided for review document that the employee has a partial tear in the rotator cuff of the left shoulder with decrease range of motion despite conservative care. The request for Orthopedic consult is **medically necessary and appropriate.**

2) Regarding the request for pain management consult for the lumbar spine:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition (2004), Chapter

7, pg. 127, which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated MTUS did not address the issue at dispute and found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on May 4, 2010 to the left shoulder, left hip, upper and lower back. Medical records provided for review indicate treatments have included nerve blocks/injections, narcotic pain medication, physical therapy, transcutaneous electrical nerve stimulation, and acupuncture. The request is for a pain management consult for the lumbar spine.

The ACOEM guidelines indicate a referral can be made if a treatment plan could benefit from additional expertise. The medical records reviewed document the employee has been treated by a pain management consultant for the left shoulder and the left upper extremity, but there is no documentation of pain management for the lumbar spine for the past year. Based on the medical records reviewed, guideline criteria for the need for additional expertise to benefit the treatment plan has been met. The request for pain management consult for L/S **is medically necessary and appropriate.**

3) Regarding the request for Medrox Patch #10:

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 (May, 2009), pg. 105, 112-113, 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 a work-related injury on May 4, 2010 to the left shoulder, left hip, upper and lower back. Medical records provided for review indicate treatments have included nerve blocks/injections, narcotic pain medication, physical therapy, transcutaneous electrical nerve stimulation, and acupuncture. The request is for Medrox Patch #10.

The MTUS Chronic Pain guidelines state that the topical analgesics are recommended when trials of both antidepressants and anticonvulsants therapy have failed. The medical records provided for review indicate that the employee was first placed on Gabapentin, but the medication was not tolerated. Then the employee was placed on Topamax, an anticonvulsant. The medical records do not document a failure of antidepressants. Medrox is a compound of methyl salicylate, menthol and capsaicin. Capsaicin would only be recommended if for those who have not responded or are intolerant to other treatments. The medical records reviewed document response to other treatment. The request for Medrox Patch #10 **is not medically necessary and appropriate.**

4) Regarding the request for Terocin lotion 240 ml:

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 105, 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 a work-related injury on May 4, 2010 to the left shoulder, left hip, upper and lower back. Medical records provided for review indicate treatments have included nerve blocks/injections, narcotic pain medication, physical therapy, transcutaneous electrical nerve stimulation, and acupuncture. The request is for Terocin lotion 240 ml.

The MTUS Chronic Pain guidelines specifically states that Lidocaine is only recommended in the form of a dermal patch and other formulations of lidocaine whether cream, lotion, or gels are not approved for neuropathic pain. Terocin is a compounded topical lotion that contains Lidocaine. The request for Terocin lotion 240 ml **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

/hs

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.