
Notice of Independent Medical Review Determination

Dated: 9/5/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/18/2013

11/3/2010

7/24/2013

CM13-0003014

- 1) MAXIMUS Federal Services, Inc. has determined the request for Ibuprofen 800mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for APAP w/Codeine 300/60mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Alprazolam 0.5mg **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for left wrist steroid injection **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 Ibuprofen 800mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for APAP w/Codeine 300/60mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Alprazolam 0.5mg **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for left wrist steroid injection **is 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 18, 2013.

“DOI : 11/03/2011

“Primary treating physician's orthopedic evaluation dated 12/22/11 states claimant complains of persistent pain in the left hand/wrist radiating into the left elbow and forearm. The left hand/wrist and left elbow pain increases with lifting, gripping and twisting motions. There is weakness of grip with the left hand. The claimant reports burning and cramping affecting the left hand. There is marked lower back pain that is increased with bending, lifting and stooping activities. There is stiffness of the lower back, pain in the anterior aspect of both knees and numbness and tingling sensations in the left lower extremity. The claimant reports depression and anxiety which the claimant relates to work injury. The claimant takes Xanax for this condition under the care of Dr. [REDACTED]. The claimant currently takes Ibuprofen for left hand pain and pain medication for low back and left hand. Examination of the lower back reveals well localized sensory deficits in the left leg and foot. There is positive straight raising test bilaterally, with left side much more involved than the right. There is decreased range of motion of the lower back secondary to pain. There is sciatic notch pain and Lasegue's sign on the left side.

There is pain with back motion. Examination of the left elbow reveals well localized pain in the ulnar groove and lateral humeral epicondylar area. There is sensory deficit in the fourth and fifth fingers of the left hand. There is full range of motion of the left elbow despite pain. There is pain with gripping. Examination of the left hand and wrist reveals sensory deficit in the median nerve distribution and ulnar nerve distribution in the left hand. There is decreased range of motion of the left wrist. There is positive Tinel's sign, positive Phalen's sign and positive Finkelstein's noted. There is weakness of grip secondary to pain. There is pain over the flexor tendons and first extensor compartment. Examination of both knees reveals patellofemoral pain in both knees. Squatting increases patellofemoral pain. Provider recommends restarting physical therapy. The provider notes that claimant continues to work and manages symptoms with medicine.

"QME report dated 09/12/12 indicates the claimant's low back pain condition, and the symptoms of the left wrist/hand have reached a state of maximum medical improvement, and as of 09/12/12 are permanent and stationary. Future industrial medical care should consist of access to the primary treating physician for medication management including the Medrol-Dosepak if necessary. This should also include a limited number of physical therapy for the low back pain as well as the left upper extremity if prescribed by the primary treating physician. In case of flare-ups of the low back pain, it would be reasonable for the claimant to be evaluated by an orthopedic surgeon in consideration for diagnostic epidural injection with the claimant's consent. With regards to the left upper extremity, the provider would recommend that the claimant has a night extension splint TMM - Date Received: 7/19/2013 – 1986242 for the left elbow. These can be done by an occupational therapist. This can consist of a very light poly-form extension splint on the volar side with Velcro straps to keep the elbow from hyperflexion, primarily during night. This can be addressed and recommended by the orthopedic surgeon with the claimant's understanding for the reasons behind the ulnar nerve entrapment at the elbow. The medical care for the lumbar spine and the left hand/upper extremity should be provided consistent with the latest California Medical Treatment Utilization Schedule at the time treatment is sought.

"PR-2 dated 04/03/13 indicates the claimant reports a herniated nucleus pulposus of the low back specifically at LS-S 1. The claimant also notes left leg radiculopathy. The claimant also complains of left hand/wrist/elbow pain. On examination, lumbar flexion is 50 degrees, extension is 15 degrees, and right and left bending are 15 and 20 degrees, respectively. Positive sciatic notch is noted on the left. Provider recommends wrist support as needed. The claimant may continue the present job. The rest of the handwritten note is illegible.

"PR-2 dated 06/26/13 indicates the claimant has a herniated nucleus pulposus at L5-S1. The claimant complains of left wrist/hand/elbow pain. There is positive radiculopathy of the lumbar spine. On examination, there is marked pain of the wrist. Lumbar flexion is 55 degrees, extension is 20 degrees, and right and left bending are 20 and 15 degrees, respectively. Provider recommends left wrist injection, pool exercises, and Ibuprofen 800 mg, Acetaminophen with Codeine 300/60 mg, and Alprazolam 0.5 mg. The claimant will not be seen for another 60-120 days and future refills are available upon authorization."

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 7/24/2013)
- Utilization Review from (7/18/2013)
- Medical records from 9/04/2012 through 6/26/2013
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Ibuprofen 800mg:

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, Ibuprofen, page 72. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee injured the low back and left wrist in a slip and fall accident on 11/03/2011. According to the submitted and reviewed medical records the employee has had x-rays, MRIs, nerve conduction studies, physical therapy, and pain medication. The most recent medical report received, dated 6/26/2013, indicated that the employee continued to have low back and left wrist pain subjectively and objectively. A request was submitted for Ibuprofen 800mg, APAP w/Codeine 300/60mg, Alprazolam 0.5mg, and left wrist steroid injection.

The MTUS Chronic Pain Guidelines indicate that sufficient clinical improvement should be observed to offset potential risk of treatment with increased dose of all medications, including Ibuprofen and other NSAIDs. The submitted documents do not indicate sufficient improvement has taken place despite previous use of the medication at issue. Additionally, the requested prescription was submitted without quantity or frequency instructions allowing for monitoring of efficacy. The request for Ibuprofen 800mg is not medically necessary and appropriate.

2) Regarding the request for APAP w/Codeine 300/60mg:

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, page 92, 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 applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee injured the low back and left wrist in a slip and fall accident on 11/03/2011. According to the submitted and reviewed medical records the employee has had X-Rays, MRIs, Nerve Conduction Studies, physical therapy,

and pain medication. The most recent medical report, dated 6/26/2013 indicated that the employee continued to have low back and left wrist pain subjectively and objectively. A request was submitted for Ibuprofen 800mg, APAP w/Codeine 300/60mg, Alprazolam 0.5mg, and left wrist steroid injection.

MTUS Chronic Pain Guidelines indicate that Codeine should be used with caution in patients with a history of drug abuse. The reviewed medical records indicate that the requested prescription was submitted without quantity or frequency instructions allowing for monitoring of efficacy and potential abuse. The request for APAP w/Codeine 300/60mg is not medically necessary and appropriate.

3) Regarding the request for Alprazolam 0.5mg:

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, page 22, 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 applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee injured the low back and left wrist in a slip and fall accident on 11/03/2011. According to the submitted and reviewed medical records the employee has had X-Rays, MRIs, Nerve Conduction Studies, physical therapy, and pain medication. The most recent medical report, dated 6/26/2013 indicated that the employee continued to have low back and left wrist pain subjectively and objectively. A request was submitted for Ibuprofen 800mg, APAP w/Codeine 300/60mg, Alprazolam 0.5mg, and left wrist steroid injection.

The MTUS Chronic Pain Guidelines indicate that benzodiazepines, including Alprazolam are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. The reviewed medical records indicate that the requested prescription was submitted without quantity or frequency instructions allowing for monitoring of efficacy and potential abuse. The request for Aprazolam 0.5mg is not medically necessary and appropriate.

4) Regarding the request for left wrist steroid injection:

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) guidelines, 2004, 2nd Edition, Forearm, Wrist, and Hand Complaints, Injection Therapy, page 265. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee injured the low back and left wrist in a slip and fall accident on 11/03/2011. According to the submitted and reviewed medical records the employee has had X-Rays, MRIs, Nerve Conduction Studies, physical therapy, and pain medication. The most recent medical report, dated 6/26/2013 indicated that the employee continued to have low back and left wrist pain subjectively and objectively. A request was submitted for Ibuprofen 800mg, APAP w/Codeine 300/60mg, Alprazolam 0.5mg, and left wrist steroid injection.

The MTUS ACOEM guidelines indicate that steroid injections are recommended for carpal tunnel syndrome for patients who are resistant to conservative therapy for eight to twelve weeks. The reviewed medical records indicate that the employee has been treated with physical therapy, medication, activity modification, and splinting for over one year without significant improvement. The guideline criteria have been met to proceed with a steroid injection. The request for left wrist steroid injection is 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.