
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/26/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/10/2013
Date of Injury: 7/12/2007
IMR Application Received: 7/24/2013
MAXIMUS Case Number: CM13-0003139

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: PARTIAL OVERTURN. This means we decided that some (but not all) 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 Preventive Medicine and Occupational Medicine and is licensed to practice in North Carolina, New York, and Pennsylvania. 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:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

[REDACTED] is 62 year old [REDACTED] female [REDACTED] (DOH: 06/08/99) for [REDACTED] who had cumulative trauma to both upper extremities. Over the last several years the patient had had progressive increasing pain in her wrist and noted numbness and tingling has subsequently diagnosed with carpal tunnel syndrome with date of injury on 07/12/07 injuring her cervical, wrist, right shoulder, and complex regional pain syndrome. The cervical, wrists, right shoulder, and complex regional pain syndrome have been accepted by the carrier. The carrier has objected the claim for psyche. She is currently TTD.

IMR DECISION(S) AND RATIONALE(S)

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

1. MRI of the thoracic spine 3.0 Tesla QTY: 1.00 is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines and Chronic Pain Medical Treatment Guidelines.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition (2004), Chapter 8, pages 169 and 178, which are part of the MTUS.

The Physician Reviewer's decision rationale:

This claimant stated she developed pain below the right shoulder due to work activities. She was diagnosed with right carpal tunnel syndrome due to repetitive work from 5/1/01. She had a release on 8/28/07 with resultant CRPS in the right arm. She had a motor vehicle accident on the way to PT, which aggravated her neck, shoulder and spine pain. She has another claim 12/29/08

with low back pain from moving and archiving boxes. Her pain is mostly in the right arm and shoulder. Diminished sensation is in the L5/S1 dermatomes, not thoracic level. CT scan results 4/6/13 showed mild osteoarthritis, possible disc bulge at C6-7 (cervical), moderate disc bulging or possible herniation at T7-8 with mild degree of scoliosis. She has already had two thoracic spine MRI studies – January and February 2013. On p. 169 of the ACOEM 2nd Edition treatment guidelines, they note that a patient with upper back pain is most often related to the neck (C4, C5), which has been thoroughly investigated already. An MRI is to be considered (p. 178) when surgery is being considered for a specific anatomic defect or to further evaluate the possibility of potentially serious pathology, such as a tumor. There is no indication in the records that either of these is the case.

2. Vicodin 5/500mg QTY: 90.00 is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines and Chronic Pain Medical Treatment Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 91, which is part of the MTUS.

The Physician Reviewer's decision rationale:

This claimant stated she developed pain below the right shoulder due to work activities. She was diagnosed with right carpal tunnel syndrome due to repetitive work from 5/1/01. She had a release on 8/28/07 with resultant CRPS in the right arm. She had a motor vehicle accident on the way to PT, which aggravated her neck, shoulder and spine pain. She has another claim 12/29/08 with low back pain from moving and archiving boxes. Pain level has not improved on narcotics, nor has her functional level. The goal of opioid therapy in the setting of chronic pain is to maximize function. On p. 91 of the chronic pain guidelines, opioids are to be avoided to "chase pain." She is deemed to be unable to work, and the goal for improved function is not clear in the request for opioid medication. It does not appear appropriate at this time.

3. Transdermal compounds QTY: 2.00 is medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines and Chronic Pain Medical Treatment Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-113, which are part of the MTUS.

The Physician Reviewer's decision rationale:

This claimant stated she developed pain below the right shoulder due to work activities. She was diagnosed with right carpal tunnel syndrome due to repetitive work from 5/1/01. She had a release on 8/28/07 with resultant CRPS in the right arm. She had a motor vehicle accident on the way to PT which aggravated her neck, shoulder and spine pain. She has another claim 12/29/08 with low back pain from moving and archiving boxes. Per the Chronic Pain Guidelines, pp. 111-113, it is reasonable to trial the use of a topical pain patch (non systemic), even though there is not a lot of clinical evidence to support this use. The request is unclear on where these patches will be used, but if used in the upper extremity for neuropathic pain, it is appropriate. She has tried medications, such as gabapentin and Cymbalta to manage the neuropathic pain already, so it is reasonable to try a topical medication.

4. Flexeril 7.5mg QTY: 60 is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines and Chronic Pain Medical Treatment Guidelines.

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

The Physician Reviewer's decision rationale:

This claimant stated she developed pain below the right shoulder due to work activities. She was diagnosed with right carpal tunnel syndrome due to repetitive work from 5/1/01. She had a release on 8/28/07 with resultant CRPS in the right arm. She had a motor vehicle accident on the way to PT which aggravated her neck, shoulder and spine pain. She has another claim 12/29/08 with low back pain from moving and archiving boxes. Per the Chronic Pain Treatment Guidelines: Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant. Flexeril is recommended as an option for treatment, using a short course of therapy. Cyclobenzaprine (Flexeril®) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. Dosing is 5 mg three times a day. Can be increased to 10 mg three times a day. This medication is not recommended to be used for longer than 2-3 weeks. It is not a medication indicated for CRPS in the treatment guidelines. There is no low back pain accepted on this claim. It is not appropriate for wrist or shoulder pain, which are on the claim. It is not listed in recommended treatment for chronic neck pain. There is no indication for Flexeril use per the treatment guidelines.

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]

CM13-0003139