
Notice of Independent Medical Review Determination

Dated: 10/22/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/11/2013

5/10/2012

7/25/2013

CM13-3355

- 1) MAXIMUS Federal Services, Inc. has determined the request for DNA pain profile testing **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for intramuscular injection of Toradol **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for intramuscular injection of Vitamin B-12 complex **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for acupuncture for an additional eight visits **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for transdermal Fluriflex cream **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for transdermal TGHOT cream **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 DNA pain profile testing **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for intramuscular injection of Toradol **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for intramuscular injection of Vitamin B-12 complex **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for acupuncture for an additional eight visits **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for transdermal Fluriflex cream **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for transdermal TGHOT cream **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The 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 11, 2013:

"Review of the medical documentation identifies the patient sustained an industrial injury on 05/10/12. The patient has been under the care of the treating physician for left-sided C5-6 radiculopathy, cervical hyperextension/hyperflexion injury, and cervical discopathy.

The most recent evaluation dated 06/13/13 is provided for review. The patient presented with complaints of ongoing pain to her cervical spine and bilateral upper extremities. She notes onset two weeks ago with increased ulnar nerve irritation, decreased sensation in the left upper extremity and tingling on the right with shooting pain on activity. Objective findings reveal cervical spine tenderness and spasm to the

cervical paraspinal muscles. There is painful rotation with overhead reach. There is weakness. There is mild left ulnar nerve sensation with mild Tinel's sign of the elbow. There is decreased grip on the right. There is overhead reach pain and weakness to the bilateral shoulders right greater than left."

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 7/25/13)
- Utilization Review Determination from [REDACTED] (dated 7/11/13)
- Employee Medical Records from [REDACTED]
- Medical Records from Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request DNA pain profile testing :

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), (current version), Pain Chapter, a medical treatment guideline (MTG), not part of the MTUS. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the Official Disability Guidelines (ODG), (current version), Pain Chapter, Genetic testing for potential opioid abuse, Cytokine DNA testing, an MTG not part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 5/10/12. The submitted medical records note ongoing pain in the cervical spine and bilateral upper extremities. The employee's diagnoses include left-sided C5-6 radiculopathy, cervical hyperextension/hyperflexion injury and cervical discopathy. The submitted medical records indicate that prior treatment has included medications and injections. A request has been submitted for DNA pain profile testing.

The Official Disability Guidelines do not recommended genetic testing for potential opioid abuse. The guidelines note that while there appears to be a strong genetic component to addictive behavior, current research is experimental in terms of testing for this. Per the submitted medical records, the testing has been requested to determine genetic predisposition towards addiction and opioid tolerance. The requested DNA pain profile testing **is not medically necessary and appropriate.**

2) Regarding the request for intramuscular injection of Toradol :

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), (current version), Pain Chapter. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Guidelines, Ketorolac, pg. 72, part of the MTUS and the Official Disability Guidelines, (current version), Pain Chapter, Toradol and NSAIDs, a medical treatment guideline not part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 5/10/12. The submitted medical records note ongoing pain in the cervical spine and bilateral upper extremities. The employee's diagnoses include left-sided C5-6 radiculopathy, cervical hyperextension/hyperflexion injury and cervical discopathy. The submitted medical records indicate that prior treatment has included medications and injections. A request has been submitted for intramuscular injection of Toradol.

The MTUS Chronic Pain guidelines note that Ketorolac (Toradol) is not indicated for minor and chronic painful conditions and the Official Disability Guidelines indicate there is inconsistent evidence for the use of Ketorolac (Toradol) to treat long-term neuropathic pain. The submitted medical records show that the employee has intramuscular Toradol injections on 4/05/12 and 5/10/13, with no discussion of efficacy. There does not appear to be any significant change in examination findings or subjective complaints from 3/18/13 through 6/13/13. The submitted medical records do not support the need for intramuscular Toradol. The requested intramuscular injection of Toradol **is not medically necessary and appropriate.**

3) **Regarding the request intramuscular injection of Vitamin B-12 complex:**

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), (current version), Pain Chapter, a medical treatment guideline (MTG) not part of the MTUS. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the Official Disability Guidelines (ODG), (current version), Pain Chapter, Vitamin B, a MTG not part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 5/10/12. The submitted medical records note ongoing pain in the cervical spine and bilateral upper extremities. The employee's diagnoses include left-sided C5-6 radiculopathy, cervical hyperextension/hyperflexion injury and cervical discopathy. The submitted medical records indicate that prior treatment has included medications and injections. A request has been submitted for intramuscular injection of Vitamin B-12 complex .

The Official Disability Guidelines recommended against Vitamin B-12 injections for treating neuropathy. Per the submitted medical records, the employee's physician states Vitamin B-12 injections were to help with pain. However, there was no benefit discussed from prior Vitamin B-12 injections or the injections on 4/05/13 and 5/10/13. The requested intramuscular injection of Vitamin B-12 complex **is not medically necessary and appropriate.**

4) **Regarding the request acupuncture for an additional eight visits :**

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

The Claims Administrator based its decision on the Acupuncture Medical Treatment Guidelines, which is part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Acupuncture Medical Treatment Guidelines, pg. 8-9, a MTG not part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 5/10/12. The submitted medical records note ongoing pain in the cervical spine and bilateral upper extremities. The employee's diagnoses include left-sided C5-6 radiculopathy, cervical hyperextension/hyperflexion injury and cervical discopathy. The submitted medical records indicate that prior treatment has included medications and injections. A request has been submitted for acupuncture for an additional eight visits.

The MTUS Acupuncture guidelines note that there should be some sign of functional improvement within three to six sessions. The submitted medical records indicate that the employee had six sessions of acupuncture, but there was no change in subjective complaints or objective findings or any discussion of functional improvement. The requested acupuncture for an additional eight visits **is not medically necessary and appropriate.**

5) **Regarding the request transdermal Fluriflex 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, Topical Analgesics, 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 a work-related injury on 5/10/12. The submitted medical records note ongoing pain in the cervical spine and bilateral upper extremities. The employee's diagnoses include left-sided C5-6 radiculopathy, cervical hyperextension/hyperflexion injury and cervical discopathy. The

submitted medical records indicate that prior treatment has included medications and injections. A request has been submitted for transdermal Fluriflex cream.

The MTUS Chronic Pain guidelines note that “Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended”. The guidelines further note that baclofen and other muscle relaxants are not recommended as a topical product. The muscle relaxant cyclobenzaprine component of the topical Fluriflex is not recommended, so the Fluriflex is not recommended. The requested transdermal Fluriflex cream **is not medically necessary and appropriate.**

6) **Regarding the request transdermal TGHOT 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, Topical Analgesics, 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 a work-related injury on 5/10/12. The submitted medical records note ongoing pain in the cervical spine and bilateral upper extremities. The employee’s diagnoses include left-sided C5-6 radiculopathy, cervical hyperextension/hyperflexion injury and cervical discopathy. The submitted medical records indicate that prior treatment has included medications and injections. A request has been submitted for TGHOT cream.

The guidelines do not support the requested TGHOT cream. There is no discussion of what medications TGHOT cream is composed of. Since the components of TGHOT cream is unknown, it cannot be confirmed to be in accordance with guidelines. The requested TGHOT 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

/srb

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.