
Notice of Independent Medical Review Determination

Dated: 10/29/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/1/2013
Date of Injury: 1/25/2010
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003631

- 1) MAXIMUS Federal Services, Inc. has determined the request for tramadol ER 150mg #30 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Dendracin lotion 120ml **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20mg #60 **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 7/1/2013. 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 tramadol ER 150mg #30 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Dendracin lotion 120ml **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20mg #60 **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 Family Practice 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 1, 2013:

This 51 year-old female was injured 1/25/10. The mechanism of injury was not provided to this reviewer. The carrier has accepted the claim for the left fingers, wrist, and thumb. No surgery has been reported to this reviewer relative to this injury. The requesting provider's medical report dated 5/30/13 stated that the patient complained of pain left wrist radiates to forearm. Pain left thumb. index finger. Numbness. Objective: She has limited range of motion of the left wrist and thumb. There is tenderness on the base of the left thumb. Strength in the left upper extremity equals 3/5. Plan and request: Dispensed: Tramadol ER 150 mg. Naproxen 550 mg. Prilosec 20 mg. Dendracin Lotion 120 ml.

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
- Utilization Review Determination from Claims Administrator
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for tramadol ER 150mg #30:

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), Opioids, Central acting analgesics, page 75, part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, (2009), Tramadol (Ultram®), page 113, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained an industrial injury on 1/25/10. The medical records submitted for review indicate treatment has included: surgical tendon A1 pulley release of the thumb and first finger, medications, and steroid injections. A reviewed medical report dated 6/27/13 indicates tenderness of the left wrist on exam. A request has been submitted for tramadol ER 150mg #30.

MTUS Chronic Pain guidelines note that tramadol is not a first-line treatment for analgesia. Tramadol is an opioid derivative which requires a pain agreement. The submitted medical records do not document a pain management contract for chronic use of tramadol. A medical report from 5/13/13 does not document functional response or pain scale improvement with the use of tramadol. The guidelines do not support the requested medication in this case. The request for tramadol ER 150mg #30 **is not medically necessary and appropriate.**

2) Regarding the request for Dendracin lotion 120ml:

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), Topical analgesics, (page not cited), part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, (2009), Topical analgesics, page 111, part of the MTUS, applicable and relevant and appropriate to the issue at dispute.

Rationale for the Decision:

The employee sustained an industrial injury on 1/25/10. The medical records submitted for review indicate treatment has included: surgical tendon A1 pulley release of the thumb and first finger, medications, and steroid injections. A reviewed medical report dated 6/27/13 indicates tenderness of the left wrist on exam. A request has been submitted for Dendracin lotion 120ml.

MTUS Chronic Pain guidelines for topical analgesics note that a compounded product is not recommended if it contains at least one drug that is not recommended. In this case, there is a lack of medical evidence indicating that Dendracin helps wrist pain or joint pain. In addition, Capsaicin .0375% is an ingredient of Dendracin. The guidelines do not support Capsaicin in a dose greater than .025%. The topical salicylates contained in Dendracin are

appropriate; however, the compounded combination of salicylate and Capsaicin is not in accordance with MTUS guidelines. The request for Dendracin lotion 120ml **is not medically necessary and appropriate.**

3) Regarding the request for Prilosec 20mg #60:

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), GI symptoms & cardiovascular risk, page 68, 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 1/25/10. The medical records submitted for review indicate treatment has included: surgical tendon A1 pulley release of the thumb and first finger, medications, and steroid injections. A reviewed medical report dated 6/27/13 indicates tenderness of the left wrist on exam. A request has been submitted for Prilosec 20mg #60.

MTUS Chronic Pain guidelines note that use of proton pump inhibitors (PPIs), Prilosec, for greater than one year has been shown to increase the risk of hip fractures. Prilosec may be used when there is a high risk of gastrointestinal (GI) events such as bleeding ulcers and peptic ulcer disease. The submitted medical records do not document the employee is at risk for GI events besides symptoms of gastritis which improved in 2011, and the employee has been on this medication for greater than one year. The risk of using this drug is likely greater than the benefit. The requested Prilosec 20mg #60 **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.