

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/15/2013

4/20/2001

8/5/2013

CM13-0007067

- 1) MAXIMUS Federal Services, Inc. has determined the request for **left shoulder major joint injection is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Topamax 50mg #60 with one refill is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20mg #30 with one refill is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325 #180 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/30/2013. 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 **left shoulder major joint injection is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Topamax 50mg #60 with one refill is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20mg #30 with one refill is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325 #180 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.

Expert Reviewer Case Summary:

The patient is a 62-year-old female who reported an injury on 04/20/2001. The mechanism of injury is not specifically stated. The patient has continued complaints of persistent neck pain and has been treated with Norco, Topamax, Klonopin, Motrin, Effexor, Flexeril, Xanax, and trazodone as well as a left shoulder glucocorticosteroid injection. Examination on 07/19/2013 revealed the patient rated her pain 3/10 with medication and 8/10 without medication as well as improved ability to perform activities with medication when compared without. The prior shoulder injection reportedly provided 95% pain relief for several months. Diagnoses include pain in shoulder, myalgia/myositis, headache, degenerative disc disease of the cervical spine, facet arthropathy, rotator cuff repair, chronic pain syndrome and impingement with bursitis/tendinitis. Treatment plan included left shoulder major joint injection, Topamax 50mg #60 with one refill, Prilosec 20mg #30 with one refill, and Norco 10/325 #180.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for left shoulder major joint injection:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the CA MTUS 2009: Shoulder Complaints, ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, (2008 Revision)- pg. 555-556, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter, (ACOEM Practice Guidelines, 2nd Edition (2004) Chapter 9)-Shoulder Disorders-Rotator Cuff Tendinopathies, Subcromial Injections, pg. 201-205, a part of the MTUS.

Rationale for the Decision:

California MTUS/ACOEM Practice Guidelines state that subacromial glucocorticosteroid injections are moderately recommended for treatment of acute, subacute, and chronic rotator cuff tendinopathies. Glucocorticosteroids are widely used for treatment of rotator cuff related disorders. Patients should generally have failed prior treatment with NSAIDs and exercise. After a review of the medical records provided, physical examination of the left shoulder prior to the injection indicated only tenderness to palpation with positive impingement sign. It was noted that the employee completed a course of physical therapy and acupuncture; however, documentation of the employee's unresponsiveness to each of these programs was not provided. The employee is reporting 3/10 pain with oral medications and improved function. The requested injection is not supported given the employee's pain relief from oral medications and lack of functional deficits resulting from the shoulder. Based on the clinical information received and the California ACOEM Practice Guidelines, **the request for a left shoulder major joint injection is not medically necessary and appropriate.**

2) Regarding the request for Topamax 50mg #60 with one refill:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 21, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pgs. 15-21, which is a part of the MTUS.

Rationale for the Decision:

California MTUS Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. Topamax is considered for use for neuropathic pain when other anticonvulsants have failed. After a review of the medical records submitted, there is no documentation of a failure of first line therapy with anticonvulsants prior to the request for Topamax. There is also no evidence upon physical examination or clinical findings of neuropathic pain for this employee that would respond to treatment with an anticonvulsant medication. Therefore, ongoing use cannot be determined as medically appropriate at this time. The request for **Topamax 50 mg #60 with 1 refill is not medically necessary and appropriate.**

3) Regarding the request for Prilosec 20mg #30 with one refill:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 67-69, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 68, which is a part of the MTUS.

Rationale for the Decision:

CA MTUS Chronic Pain Medical Treatment Guidelines note it should be determined if the patient is at risk for gastrointestinal events to include over the age of 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant or high dose/multiple NSAID. After a review of the medical records submitted, there is no evidence of this employee's risk of gastrointestinal events. Physical examination at each clinical office visit indicated no gastrointestinal events other than constipation. The employee did not complain of gastrointestinal symptoms that would require the use of a proton pump inhibitor. Based on the clinical information received for recommended and the CA MTUS Chronic Pain Medical Treatment Guidelines, the request for **Prilosec 20 mg #30 with 1 refill is not medically necessary and appropriate.**

4) Regarding the request for Norco 10/325 #180:

Section of the Medical Treatment Utilization Schedule 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), Second edition (2004), Chapter 3, pg. 47-49, a part of the MTUS and the Chronic Pain Medical Treatment Guidelines, (2009), pages 78-80, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 72-82, which is a part of the MTUS.

Rationale for the Decision:

California MTUS Guidelines state that short acting opioids are effective in controlling chronic pain. They are often used for intermittent or breakthrough pain. The duration of action is generally 3 to 4 hours. The use of opioids should be part of a treatment plan that is tailored to the patient. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. After a review of the medical records submitted, there is no documentation indicating a failure of nonopioid analgesics prior to the request for an opioid. Guidelines further state that a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, treatment plan, and informed consent. There is not documentation supporting monitoring of the employee with the use of urine drug screens. The request for **Norco 10/325 mg #180 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/pr

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.