MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 12/4/13

Employee:	
Claim Number:	
Date of UR Decision:	7/24/2013
Date of Injury:	6/22/2011
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007165

1) MAXIMUS Federal Services, Inc. has determined the request for **Terocin lotion 120ml is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **30gm Flurbiprofen 25% is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **30gm Cyclobenzaprine 10% is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol 10% 120gm tube is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request **for EMG/NCV BUE (Electromyogram/Nerve Conduction Studies of the Bilateral Upper Extremities) is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the request for **MRI (Magnetic Resonance Imaging scan) thoracic spine is not medically necessary and appropriate.**

7) MAXIMUS Federal Services, Inc. has determined the request for **one year gym membership 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 7/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/4/2013. 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 **Terocin lotion 120ml is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **30gm Flurbiprofen 25% is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **30gm Cyclobenzaprine 10% is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol 10% 120gm tube is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request for **EMG/NCV BUE is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the request **for MRI thoracic spine is not medically necessary and appropriate.**

7) MAXIMUS Federal Services, Inc. has determined the request for **one year gym membership 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 Occupational Medicine and is licensed to practice in North Carolina, New York, 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 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:
This 44 year old man was injured 6/22/11, and his treating physician states he has a permanent disability. Dr. [redacted] states that he has a crush injury to his hip, thigh, and upper extremity, in addition to lumbosacral sprain after being in a motor vehicle accident (MVA). Another vehicle (tug) hit his tug on the driver's side, pinning his left hand and left leg between the two vehicles. He has had other prior injuries involving his upper extremity, including medial epicondylitis, and a crush injury to the right hand 5/19/11. He was deemed to have a permanent and stationary status.

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 Employee/Employee Representive
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for Terocin lotion 120ml:**

   The Medical Treatment Guidelines 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, pages 111 - 112, which is part of the MTUS.

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-112, which is part of the MTUS.

   Rationale for the Decision:
   Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Terocin is not recommended in the care of this employee. **The request for Terocin lotion 120ml is not medically necessary and appropriate.**

2) **Regarding the request for 30gm Flurbiprofen 25%:**

   The Medical Treatment Guidelines 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, pages 111 - 112, which is part of the MTUS.

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-112, which is part of the MTUS.

Rationale for the Decision:
Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Clinical trials have shown variability in efficacy of topical NSAIDs (Non-Steroidal Anti-Inflammatory Drugs), per the Chronic Pain Medical Treatment Guidelines. Topical NSAIDs are recommended for knee, elbow or other joints amenable to topical treatment for osteoarthritis and tendonitis. Topical Voltaren Gel is what is recommended, and FDA-approved. Flurbiprofen is not included in the recommendations. **The request for 30gm Flurbiprofen 25% is not medically necessary and appropriate.**

3) **Regarding the request for 30gm Cyclobenzaprine 10%:**

The Medical Treatment Guidelines 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, pages 111 - 112, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-112, which is part of MTUS.

Rationale for the Decision:
Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. According to the Chronic Pain Medical Treatment Guidelines, there is no evidence for use of cyclobenzaprine (muscle relaxant) as a topical product. **The request for 30gm Cyclobenzaprine 10% is not medically necessary and appropriate.**

4) **Regarding the request for Tramadol 10% 120gm tube:**

The Medical Treatment Guidelines 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 Analgesic, pages 111 - 112, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-112, which is part of MTUS.

Rationale for the Decision:
Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Tramadol is not listed as a topical agent that is recommended in the Chronic Pain Guidelines. **The request for Tramadol 10% 120gm tube is not medically necessary.**

5) **Regarding the request for EMG/NCV BUE) :**

The Medical Treatment Guidelines 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), Electromyography (EMG) and nerve conduction velocities, (NVC), which is part of MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Special Studies and Diagnostic and Treatment Considerations, pages 177-178, which is part of MTUS.

Rationale for the Decision:
The ACOEM Practice Guidelines state that "EMG and nerve conduction velocities can be performed when physiologic evidence of nerve dysfunction is being sought when not unequivocally evident on neurologic examination and symptoms last more than 3-4 weeks. Sensory-evoked potentials may be included if spinal stenosis or spinal cord myelopathy is suspected." The employee had electrodiagnostic testing 11/4/2011 showing chronic left ulnar neuropathy and left C6 neuropathy. Lower extremity testing 9/24/12 was normal. There is no indication for repeat testing as there is no significant change in the neurologic examination evident. **The request for EMG/NCV BUE is not medically necessary or appropriate.**

6) **Regarding the request for MRI (Magnetic Resonance Imaging scan) thoracic spine:**

The Medical Treatment Guidelines 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), which is part of MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Special Studies and Diagnostic and Treatment Considerations, pages 177-178, which is part of MTUS.

Rationale for the Decision:
The ACOEM Treatment Guidelines states that imaging is indicated for neck and upper back complaints that persist after 3-4 weeks of conservative care. Additional criteria are: the emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. In this case, the employee is complaining of tingling in the left middle finger, and over the left lower extremity. The thoracic MRI is not indicated for work up of middle finger dysesthesias due to anatomical considerations. It is unlikely to be helpful in the lower extremity without myelopathy present. **The**

request for MRI (Magnetic Resonance Imaging scan) thoracic spine is not medically necessary or appropriate.

7) **Regarding the request forone year gym membership:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the Official Disability Guidelines, (ODG), which is not part of MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Summary of Recommendations and Evidence, Table 8-8, page 182, which is part of MTUS.

Rationale for the Decision:
The ACOEM Practice Guidelines recommends that activity levels be maintained while recovering. After initial pain decrease, office instruction on exercise is recommended; and low-stress conditioning and aerobic exercise are recommended to avoid debilitation. The recommendation is for a home program. The claimant has already had physical therapy. There is no indication for gym membership to perform exercises that can be done at home. **The request for one year gym membership is not medically necessary or 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

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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.