
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/19/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/12/2013
Date of Injury: 12/17/2006
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0007587

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: UPHOLD. This means we decided that none 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Ohio. 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:

The patient reported an injury on 12/17/2006. The patient is status post open reduction internal fixation of the left proximal humerus fracture, and a diagnosis of chronic regional shoulder myofascial pain with left adhesive capsulitis was added to the patient's diagnoses. The patient has continued pain complaints of the left shoulder. Physical findings included range of motion described as 100 degrees in abduction, 110 degrees in flexion, 20 degrees in external and internal rotation and extension limited to 20 degrees. The patient's treatment plan included home exercises, application of heat and ice and medications.

IMR DECISION(S) AND RATIONALE(S)

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

1. The request for compound medication: Amitriptyline 4%/Dextromethorphan 10%/Tramadol 20%/Ultraderm is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Analgesic Creams, which is part of MTUS and the Official Disability Guidelines (ODG), which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesic, page 111, which is part of MTUS.

The Physician Reviewer's decision rationale:

The requested compounded medication of amitriptyline 4%/dextromethorphan 10%/tramadol 20%/Ultraderm is not medically necessary or appropriate. The employee does have continued pain in the left shoulder. The California Medical Treatment Utilization Schedule states, "Largely experimental in use, with few randomized controlled trials to determine efficacy or safety. They

are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed.” The clinical documentation submitted for review does not provide evidence that the employee has failed to respond to first-line oral medications. Therefore, a topical agent would not be supported. Additionally, antidepressants, cough suppressants, tramadol and Ultraderm are not supported as topical agents. There is no documentation submitted for review that the employee is intolerant of oral antidepressants, cough and cold medications, oral analgesics such as tramadol or the oral equivalents of Ultraderm. **The request for compound medication: Amitriptyline 4%/Dextromethorphan 10%/Tramadol 20%/Ultraderm is not medically necessary and appropriate.**

2. The request for compound medication: Diclofenac 10%,/Flurbiprophen 25%/Ultraderm is not medically necessary and appropriate.

The Claims Administrator based its decision on the the Chronic Pain Medical Treatment Guidelines, Analgesic Creams, which is part of MTUS and the Official Disability Guidelines (ODG), which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesic, page 111, which is part of MTUS.

The Physician Reviewer’s decision rationale:

The requested compounded medication of amitriptyline 4%/dextromethorphan 10%/tramadol 20%/Ultraderm is not medically necessary or appropriate. The employee does have continued pain in the left shoulder. The California Medical Treatment Utilization Schedule states, “Largely experimental in use, with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed.” The clinical documentation submitted for review does not provide evidence that the employee has failed to respond to first-line oral medications. Therefore, a topical agent would not be supported. Additionally, antidepressants, cough suppressants, tramadol and Ultraderm are not supported as topical agents. There is no documentation submitted for review that the employee is intolerant of oral antidepressants, cough and cold medications, oral analgesics such as tramadol or the oral equivalents of Ultraderm. **The request for compound medication: Diclofenac 10%,/Flurbiprophen 25%/Ultraderm is not medically necessary and appropriate.**

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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.

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