

Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/18/2013
Date of Injury: 9/23/2011
IMR Application Received: 8/6/2013
MAXIMUS Case Number: CM13-0007931

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Fluriflex 15/10% cream 100gm is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **TGHot 8/10/2/.05% cream 108 gm is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **acupuncture therapy for shoulders, upper extremities, and cervical spine for two times a week for six weeks is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/9/2013. 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 **Fluriflex 15/10% cream 100gm is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **TGHot 8/10/2/.05% cream 108 gm is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **acupuncture therapy for shoulders, upper extremities, and cervical spine for two times a week for six weeks 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 66-year-old female who reported an injury on 09/23/2011 with the mechanism of injury stated to be a cumulative trauma. The patient was noted to have crepitus of the bilateral shoulders and significant irritation, spasm, tightness, and treatment in the paracervical musculature. The patient was noted to have a positive Tinel's sign bilaterally. The diagnoses were stated to include left shoulder impingement syndrome, upper extremity overuse tendonitis, and bilateral carpal tunnel syndrome. The treatment requested was noted to be acupuncture therapy, FluriFlex 15/10% cream, and TGHot 8/10/2/0.05% cream.

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 Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for Fluriflex 15/10% cream 100gm:

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, which is part of the MTUS.

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

Rationale for the Decision:

MTUS Chronic Pain Guidelines recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines indicate that any compounded cream that contains at least 1 drug (or drug class) that is not recommended is not recommended. The clinical documentation submitted for review failed to provide proof that the employee had findings of neuropathic pain. Additionally, the documentation failed to indicate that the employee had failed trials of antidepressants and anticonvulsants. The ingredients of the requested medication were also not disclosed in the supporting documentation. **The request for FluriFlex 15/10% cream 100 gm is not medically necessary and appropriate.**

2) Regarding the request for TGHOT 8/10/2/0.05% cream 108 gm:

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, which is part of the MTUS.

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

Rationale for the Decision:

MTUS Chronic Pain Guidelines recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines indicate that any compounded cream that contains at least 1 drug (or drug class) that is not recommended is not recommended. The clinical documentation submitted for review failed to provide proof that the employee had findings of neuropathic pain. Additionally, the documentation failed to indicate that the employee had failed trials of antidepressants and anticonvulsants. The ingredients of the requested medication were also not disclosed in the supporting documentation. **The request for TGHOT 8/10/2/0.05% cream 108 gm is not medically necessary and appropriate.**

3) Regarding the request for acupuncture therapy for shoulders, upper extremities, and cervical spine for two times a week for six weeks:

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 Acupuncture Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Acupuncture Medical Treatment Guidelines, pages 1, 7 and 8, which are part of the MTUS.

Rationale for the Decision:

MTUS Acupuncture Guidelines recommend acupuncture treatments when pain medication is reduced or not tolerated. The Guidelines recommend that acupuncture treatments may be extended if functional improvement is documented, including a significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical. The office note dated 06/13/2013 included in the medical records provided for review reveal that the employee had complaints of bilateral shoulder and wrist pain. The employee was noted to have pain in the neck and upper back. The physical examination revealed significant irritation, spasm, tightness, and tenderness in the paracervical musculature. The employee was noted to have crepitus in the bilateral shoulders and a positive Tinel's sign in the wrists bilaterally. The clinical documentation submitted for review indicated the employee had previous acupuncture sessions; however, it failed to provide the number of sessions, and failed to provide proof of functional improvement to support the necessity for additional acupuncture sessions. **The request for acupuncture therapy for shoulders, upper extremities, and cervical spine for 2 times a week for 6 weeks 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

/MCC

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.