

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/18/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/26/2013
Date of Injury: 5/17/2002
IMR Application Received: 8/8/2013
MAXIMUS Case Number: CM13-0008506

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 Internal Medicine and Cardiology, has a subspecialty in Fellowship trained in Cardiovascular Disease 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 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:

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

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 is a 46-year-old female who reported an injury on 05/17/2002. Current diagnoses include neck pain, carpal tunnel syndrome, myalgia, numbness, and depression. The patient was most recently seen by Ms. [REDACTED] on 08/08/2013. The patient reported a 10/10 pain without medications and a 4/10 with medications. Physical examination revealed no acute distress, 5/5 upper extremity strength bilaterally, diminished sensation to the left hand, tenderness over the cervical paraspinals, reduced cervical spine range of motion, and positive Tinel's bilaterally. The patient was given prescriptions for tramadol, omeprazole, naproxen, and Cymbalta.

IMR DECISION(S) AND RATIONALE(S)

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

1. Naproxen sodium 550mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the California MTUS, NSAIDS, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 67-72, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state Naproxen is a nonsteroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors. For acute exacerbations of chronic pain, NSAIDs are recommended as a second-line treatment after acetaminophen. As per

the clinical notes submitted, the employee demonstrated tenderness over the cervical paraspinals and trapezius, positive Tinel's testing, and diminished sensation of the left hand. There is no documentation supporting the need for ongoing prescription NSAID medication. There is also no indication as to why the employee would not benefit from over-the-counter anti-inflammatories as opposed to a prescription product. The long-term use of prescription anti-inflammatories is not supported. **The request for Naproxen sodium 550mg is not medically necessary and appropriate.**

2. Cymbalta 30mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the California MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 13-16, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state Cymbalta is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. More studies are needed to determine the efficacy of Cymbalta for other types of neuropathic pain. Dosing includes 60 mg once per day as an option for chronic pain syndromes. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. As per the clinical notes submitted on 08/08/2013, the employee continued to report neck, shoulder, upper extremity, and low back pain. The employee did not report any changes to the pain. It was also noted that the employee was seen by a psychologist in the past. However, an updated psychological report was not provided for review. Upon physical examination, the employee appeared to be in no acute distress, alert and oriented x3, well-developed, and well-nourished without signs or symptoms of distress. There has been no documentation of changes in the use of other analgesic medication, sleep quality and duration, or a psychological assessment following the treatment for chronic pain and depression with an antidepressant. Based on the clinical information received and the California MTUS Guidelines, the ongoing use of this medication cannot be determined as medically appropriate at this time. **The request for Cymbalta 30mg is not medically necessary and appropriate.**

3. Tramadol 50mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the California MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 74-82, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. If there is no overall improvement in function, opioids should be discontinued unless there are extenuating circumstances. As per the clinical notes submitted on 08/08/2013, the employee did not report satisfactory response to treatment by a decreased pain level, increased level of function, or improved quality of life. Although it was stated by the employee that her medications reduced her pain by 50%, there is no documentation of objective functional improvement following

treatment with an opioid. Physical examination revealed only tenderness over the cervical paraspinals and trapezius, positive Tinel's testing bilaterally, and diminished left hand sensation. Based on the clinical information received, the ongoing use of this medication cannot be determined as medically appropriate. **The request for Tramadol 50mg is not medically necessary and appropriate.**

4. Omeprazole 20mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 68-69, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state proton pump inhibitors are used for patients with intermediate or high risk for developing gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require a proton pump inhibitor. As per the clinical notes submitted, there is no evidence of gastrointestinal events or subjective complaints of GI symptoms that would warrant the need for a proton pump inhibitor. There is also no indication as to why the employee would not benefit from an over-the-counter medication, as opposed to a prescription product. **The request for Omeprazole 20mg is not medically necessary and appropriate.**

5. Terocin lotion is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 111, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 111-113, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Lidocaine is indicated for localized peripheral pain after there has been evidence of a trial of first-line therapy with antidepressants and anticonvulsants. Topical lidocaine in the formulation of a dermal patch has been designated by the FDA for neuropathic pain. No other commercially-approved topical formulation of lidocaine is indicated. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. It is indicated for osteoarthritis, fibromyalgia, and chronic nonspecific back pain. As per the clinical notes submitted, there is no evidence of a failure to respond to oral antidepressants or anticonvulsants prior to the initiation of a topical analgesic. The medical necessity for the requested medication has not been established. **The request for Terocin lotion is not medically necessary and appropriate.**

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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