

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/26/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/4/2013
Date of Injury:	4/14/2004
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0009689

- 1) MAXIMUS Federal Services, Inc. has determined the request for **one right de quervain's cortisone injection is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one prescription of Fexmid 7.5mg #60 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 8/4/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/18/2013. 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 **one right de quervain's cortisone injection is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one prescription of Fexmid 7.5mg #60 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 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 represented former bookkeeper who has filed a claim for chronic wrist pain, bilateral upper extremity pain, neck pain, and shoulder pain reportedly associated with an industrial injury of April 14, 2004. Thus far, the applicant has been treated with the following: Analgesic medications; a wrist brace; transfer of care to and from various providers in various specialties; attorney representation; extensive periods of time off work, on total temporary disability; unspecified amounts of chiropractic manipulative therapy; a CPAP machine; unspecified amounts of pool therapy; and adjuvant medications.

In a utilization review report of August 4, 2013, the claims administrator denied a request for corticosteroid injection, certified a wrist brace, certified Norco, and non-certified Fexmid. The applicant's attorney subsequently appealed, on August 9, 2013.

A recent clinical progress report of August 12, 2013, is notable for comments that the applicant reports persistent neck, elbow, and wrist pain. The applicant does have a positive Finkelstein's maneuver. The applicant was given refills of Fexmid and Norco while remaining off work, on total temporary disability.

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 one right de quervain's cortisone 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 Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) pg 265, which is part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition (2004), Table 11-4, which part of the MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM Guidelines in Chapter 11, Table 11-4, injections of lidocaine and corticosteroids are options in the treatment of tendinitis/tenosynovitis as is seemingly present here. In this case, it is further noted that the employee has had ongoing symptoms and complaints for what appears to be several years. Obtaining a first dorsal compartment corticosteroid injection is an appropriate option in this context. **The request for one right de quervain's cortisone injection is medically necessary and appropriate.**

2) Regarding the request for one prescription of Fexmid 7.5mg #60 :

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, Cyclobenzaprine, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 41, which is part of the MTUS.

Rationale for the Decision:

As noted on page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, addition of cyclobenzaprine to other agents is not recommended. In this case, the employee has been issued prescriptions for numerous analgesic and adjuvant medications, including Norco. Adding cyclobenzaprine or Fexmid to the mix is not indicated, particularly given the employee's failure to clearly demonstrate functional improvement through prior usage of cyclobenzaprine. Rather, the fact that the employee continues to use numerous analgesic medications, is pursuing steroid injections, remains off work, and is on total temporary disability, suggests a lack of functional improvement as defined in MTUS 9792.20(f). **The request for one prescription of Fexmid 7.5mg #60 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.