
Notice of Independent Medical Review Determination

Dated: 8/13/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/2/2013

5/7/2002

7/8/2013

CM13-0000992

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of 60 units of Tramadol ER 150mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of 120 units of Prilosec 20mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for unknown number of H-Wave patches **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/8/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/8/2013. 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 1 prescription of 60 units of Tramadol ER 150mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of 120 units of Prilosec 20mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for unknown number of H-Wave patches **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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 2, 2013

“The patient is a 52 year old female with a date of injury of 5/7/2002. The provider has submitted a retrospective request for 1 prescription of Tramadol ER 150mg #60, 1 prescription of Prilosec 20mg #120 and an unknown prescription of H-wave patches. For the purposes of this retrospective review, the determination of appropriateness of the service will be based upon the information available to the provider on or prior to the date of service.

“According to the provided notes, the patient is having ongoing left elbow pain radiating to the shoulder and hand. The patient has been diagnosed with thoracic outlet syndrome and chronic regional pain syndrome. Prior treatment has included anti-inflammatories, injections, topical analgesics, and bracing. Recently, the patient has been using Tramadol, Prilosec, Percocet and an H-wave unit. She remains temporarily totally disabled.”

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 for Independent Medical Review
- Utilization Review by [REDACTED] (dated 7/2/13)
- Medical Records by [REDACTED], M.D. (dated 6/4/12 to 7/9/13)
- Chronic Pain Medical Treatment Guidelines (2009), pages, 82-83, 113, 67-73, 117-118

1) Regarding the request for 1 prescription of 60 units of Tramadol ER 150mg:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 82-83, 113, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 88-89, which is part of the Medical Treatment Utilization Schedule (MTUS), as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee has a date of injury of 5/7/2002. The medical records provided for review indicate the employee is experiencing pain in the left elbow which radiates to the shoulder and hand. Treatment has included oral pain medication, ulnar nerve blocks, and H-wave

Chronic Pain Guidelines require documentation of the efficacy of medications for continued use. The medical records from 6/4/12 to 6/7/13 do not include any documentation of functional or subjective improvement or improved quality of life from Tramadol currently being used. The MTUS criteria for continuation of Tramadol have not been met. The prescription of 60 units of Tramadol ER 150mg **is not medically necessary and appropriate.**

2) Regarding the request for 1 prescription of 120 units of Prilosec 20mg:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 67-73, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee has a date of injury of 5/7/2002. The medical records provided for review indicate the employee is experiencing pain in the left elbow which radiates to the shoulder and hand. Treatment has included oral pain medication, ulnar nerve blocks, and H-wave

Chronic Pain Guidelines allow for the use of proton pump inhibitors if there is a gastrointestinal risk factor(s) due to the use of NSAIDs. The medical records reviewed from 6/4/12 to 6/7/13 do not document a rationale for the prescribing of Prilosec; there is no discussion of efficacy of the Prilosec; and there is no discussion regarding the gastrointestinal risk factor(s) requiring the use of Prilosec. The prescription of 120 units of Prilosec 20mg **is not medically necessary and appropriate.**

3) Regarding the request for unknown number of H-Wave patches:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not offer any evidence basis for its decision. The provider did not dispute the decision of the Claims Administrator based on lack of evidence basis. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 117-118, which is part of the Medical Treatment Utilization Schedule (MTUS) as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee has a date of injury of 5/7/2002. The medical records provided for review indicate the employee is experiencing pain in the left elbow which radiates to the shoulder and hand. Treatment has included oral pain medication, ulnar nerve blocks, and H-wave.

Chronic Pain Guidelines allow for use of H-Wave if there has been a documented TENS trial and failure with documentation of the effectiveness of the treatment for continued use. The medical records reviewed from 6/4/12 to 6/7/13 do not document the effectiveness of the H-Wave treatment other than the need for replacement pads for the unit. The request for an unknown number of H-Wave patches **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/dl

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.



