
Notice of Independent Medical Review Determination

Dated: 8/20/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/2/2013
Date of Injury: 5/25/2010
IMR Application Received: 7/9/2013
MAXIMUS Case Number: CM13-0001064

- 1) MAXIMUS Federal Services, Inc. has determined the request for refill of medications (unspecified) **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/9/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/9/2013. 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 refill of medications (unspecified) **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 claimant, Ms. [REDACTED] is a [REDACTED] custodian who has filed a claim for bilateral shoulder pain and right carpal tunnel syndrome reportedly associated with industrial injury of 5/25/10.

“Thus far, she has been treated with analgesic medications, physical therapy, work restrictions, and time off work. A prior electrodiagnostic testing report of 10/22/12, is notable for comments that the claimant has diabetes and hypertension, and the study was interpreted as normal.

“A prior note of 2/28/13, suggests that the claimant is reporting numbness and tingling about the right hand, while a prior report of 9/27/12, suggested that the claimant does also have issues with neck pain.

“The most recent progress report of 6/6/13, is notable for comments that the claimant reports significant right hand and bilateral shoulder pain, comments that the claimant is no longer able to perform modified duty work, exhibits reduced grip strength about the right wrist and diminished sensation in median nerve distribution, and receives treatment recommendations, which includes repeat electrodiagnostic testing of the bilateral upper extremities while remaining off work, on total temporary disability, for 6 weeks”

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 (received 7/9/13)
- Utilization Review Determination (dated 7/2/13)
- List of Employee's Medications from [REDACTED] (dated 7/9/13)
- Orthopedic Initial Evaluation of the Primary Treating Physician from Dr. [REDACTED], D.C., QME (dated 7/19/12)
- Medical Records from [REDACTED], MD, QME (dated 9/27/12-6/6/13)

1) Regarding the request for Refill of Medications (unspecified):

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

The Claims Administrator did not rely on any evidenced based guidelines to support their decision. The Primary Treating Provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 65, 68-69, 91 and 111 relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained an industrial injury on 5/25/10 resulting in bilateral shoulder pain and right carpal tunnel syndrome. Medical records submitted for review indicate treatment included analgesics (Medrox ointment, hydrocodone/APAP, Ketoprofen, Omeprazole, and Orphenadrine ER), physical therapy, work restrictions, and time off work. A request was submitted for refill of medications (unspecified).

MTUS Chronic Pain guidelines indicate, "Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug (or drug class) is not recommended." Monitoring of pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors is recommended in patients taking opioids. The clinical notes did not indicate the effectiveness of the current medication regimen as evidenced by decrease in rate of pain, increase in objective functional improvement, or treatment with more active therapeutic interventions. In addition, the request for refill lacked the specific medication name, dose, quantity, and refill amount requested. Therefore, the request for refill of medications unspecified **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
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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.



