

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/5/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/8/2013
Date of Injury:	8/28/2010
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004288

- 1) MAXIMUS Federal Services, Inc. has determined the request for Omeprazole 20mg #30 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Orphanadrine 100mg #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Tramadol ER 150mg #30 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Dendracin Lotion #120 **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 Omeprazole 20mg #30 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Orphanadrine 100mg #60 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Tramadol ER 150mg #30 **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Dendracin Lotion #120 **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 Preventive Medicine and 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 applicant, Ms. [REDACTED], is a represented [REDACTED] kitchen aide who has filed a claim for bilateral carpal tunnel syndrome, chronic low back pain, and chronic neck pain reportedly associated with industrial injury of August 28, 2010. Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; unspecified amounts of physical therapy; unspecified amounts of acupuncture; right carpal tunnel release surgery of February 14, 2012; prior electrodiagnostic testing of February 15, 2011, notable for mild bilateral carpal tunnel syndrome; and extensive periods of time off of work, on total temporary disability.

The most recent handwritten progress report of July 19, 2013 is difficult to follow, notable for comments that the applicant reports persistent on and off bilateral wrist pain, exacerbated by gripping, grasping, lifting, and manipulating. The applicant is presently on Norflex, Prilosec, tramadol, Neurontin, and Dendracin. Positive Tinel and Phalen signs are noted along with diminished sensation about the median nerve distribution. Recommendations are made for the applicant to continue all analgesic and adjuvant medications, pursue a left carpal tunnel release surgery, remain off of work, on total temporary disability, for additional six 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 of Independent Medical Review
- Utilization Review Determination [REDACTED]
- Medical Records from the Provider
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for Omeprazole 20mg #30 :**

##### 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, NSAIDs, GI symptoms, & cardiovascular risk, pages 68-69, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms, & cardiovascular risk, page 69, which is part of the MTUS.

##### Rationale for the Decision:

The MTUS Chronic Pain Guidelines indicate that proton pump inhibitors such as omeprazole are indicated in the treatment of NSAID-induced dyspepsia. The records in this case, however, do not provide clear evidence or description of issues with reflux, dyspepsia, and/or heartburn, either NSAID induced or stand alone. **The request for Omeprazole 20mg # 30 is not medically necessary and appropriate.**

#### **2) Regarding the request for Orphanadrine 100mg #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, muscle relaxants, page 63, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, muscle relaxants (for pain), page 63, which is part of the MTUS.

##### Rationale for the Decision:

The MTUS chronic pain guidelines indicate that muscle relaxants, such as orphenadrine (Norflex), are not recommended for chronic or long-term use purposes, particularly when used in conjunction with other medications such as NSAIDs. The records reviewed note the employee has used this particular agent chronically and failed to derive any lasting benefit or functional improvement through prior usage of the same. The employee has failed to return to work and has failed to demonstrate any improvement in terms of work status, work restrictions, activities of daily living, and/or diminished reliance on medical

treatment. The ongoing usage of numerous analgesic medications, consultation with numerous providers in numerous specialists, etc. argue against diminished reliance on medical treatment. **The request for orphanadrine 100mg # 60 is not medically necessary and appropriate.**

**3) Regarding the request for Tramadol ER 150mg #30 :**

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, Opioids, page 93, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, page 80, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain guidelines indicate that primary criteria for continuation of opioid therapy include evidence of successful return to work, improved function, and/or reduced pain. The records reviewed do not provide evidence that the employee meets any of the aforementioned criteria. The employee has failed to return to work, reports heightened pain, and the employee is now intent on pursuing a surgical remedy. **The request for Tramadol ER 150mg # 30 is not medically necessary and appropriate.**

**4) Regarding the request for Dendracin Lotion #120 :**

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, Topical Analgesics, page 111-113, which is part of the MTUS.

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

Rationale for the Decision:

The MTUS Chronic Pain guidelines indicate that oral pharmaceuticals are the most appropriate first line palliative measure. The guidelines further suggest that topical agents and topical compounds are largely experimental. The records reviewed do not provide evidence of intolerance to and/or failure of multiple classes of oral analgesic medications which might a case for usage of topical analgesics or topical compounds such as Dendracin. **The request for Dendracin lotion # 120 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

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