

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/18/2013
Date of Injury:	12/12/2011
IMR Application Received:	8/31/2013
MAXIMUS Case Number:	CM13-0005746

- 1) MAXIMUS Federal Services, Inc. has determined the request for 60 Xodol 5/300mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 240 Medi-derm .035-5-20% cream **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/31/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/20/2013. 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 60 Xodol 5/300mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 240 Medi-derm .035-5-20% cream **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 Family Practice, 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:

This is a 45 year old male who had an initial injury on 12/12/2011. He was participating in training exercises when he sustained an injury to his left elbow with a sensation of pop. He was diagnosed as having a rupture of the left biceps tendon. This male had a repair of the left biceps tendon on 1/20/12. The progress note on 3/27/12 documented the present complaints were left elbow pain, weakness, tenderness, and limitation of motion with radiating pain and paraesthesias into the forearm and hand without sensation of instability or mechanical symptoms. The symptoms were worsened with local pressure. Left forearm had tenderness to palpation over the medial compartment. There was mild limitation of range of motion of the left wrist without discomfort. There was patchy, decreased sensation in the radial nerve distribution in the left upper extremity. The treatment was medications, postoperative therapy three times a week for six weeks time, exercises for range of motion, electrodiagnostic studies and neurological consultation. The progress note on 1/29/2013 documented that this male returned for an orthopedic re-evaluation. The physical exam noted that there was a well-healed, nontender anterior incision. There was no instability and no pain with stressing. The range of motion was 0 degrees for extension, 115 degrees for flexion, 70 degrees for pronation, 40 degrees for supination with a slightly greater passive range of motion. There is grade 4/5 strength in elbow flexion, extension, pronation, and supination. The left forearm was tender to palpation over the medial compartment. The left wrist had mild limitation of range of motion without discomfort. There was satisfactory range of motion of the digits. The upper neurological exam was patchy, decreased sensation in the radial nerve distribution in the left upper extremity. The diagnosis was status post repair of the left distal biceps tendon rupture and left radial nerve neuropraxia. The treatment plan was medications for pain management. After discussion of a variety of treatment options, as was still symptomatic, this male chose to continue conservative care.

The medications under review are medi-derm 0.035-5-20% pain relief cream and Xodol 5/300. The start date for Xodol 5/300 was on 4/15/12. The start date for the medi-derm 0.035-5-20% cream was 8/15/2011.

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 Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for 60 Xodol 5/300mg :

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, Hydrocodone/Acetaminophen, Criteria for use of Opioids, when to Discontinue Opioids, and Weaning of medications, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pages 74-96, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain guidelines recommend that a treatment plan should be established. Questions such as if reasonable alternative to treatment have been tried, or is there likelihood of abuse or an adverse outcome should be asked. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain. A therapeutic trial of opioids should not be employed until there had been failure of a trial of non-opioid analgesics. Opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). It is not recommended as a first-line therapy. Hydrocodone/acetaminophen is indicated for moderate to moderately severe pain. Review of the submitted medical records does not provide any documentation to whether the employee has tried and failed non-opioid analgesics prior to continuation of the opioids. In addition there is nothing documenting that the employee has been weaned from this medication. **The request for Xodol 5/300mg #60 is not medically necessary and appropriate.**

2) Regarding the request for 240 Medi-derm .035-5-20% cream:

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, Compounded Topical Analgesics, Capsaicin, topical, Menthol and salicylate topical, which are part of the MTUS.

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

Rationale for the Decision:

The Chronic Pain guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Medi-derm is a combination cream containing methyl salicylate, menthol and capsaicin. According to the chronic pain medical treatment guidelines, topical capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. A review of the submitted medical records do not document that other alternative first-line treatments were attempted prior to using this cream. In addition, there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. This cream has 0.035% capsaicin and according to the guidelines, there is no current indication that this percentage would provide further improvement in symptoms. **The request for 240 Medi-derm .035-5-20% cream 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, 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.