
Notice of Independent Medical Review Determination

Dated: 11/19/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/24/2013
Date of Injury: 2/21/2012
IMR Application Received: 8/1/2013
MAXIMUS Case Number: CM13-0005948

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Flurbiprofen is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ketamine is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Lidocaine & Prilocaine is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Lipoderm base is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Gabapentin is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/14/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/23/2013. 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 **FFlurbiprofen is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ketamine is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Cyclobenzaprine is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Lidocaine & Prilocaine is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Lipoderm base is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Gabapentin 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.

Expert Reviewer Case Summary:

58 y.o. with 2/21/12 date of injury, s/p right shoulder surgery 6/20/12 for rotator cuff repair. The patient has recurrent impingement with persistent pain. ROM are noted to be at 170 for flexion, 120 for abduction. 3/8/13 X-ray showed corkscrew anchor, type II acromion, distal clavicle resection, degeneration of glenohumeral joint. Dr. [REDACTED] most recent office note from 6/5/13 notes that the patient underwent right shoulder second surgery with debridement of labrum, excision capture lesions, post cap release, redo ASD excision on 5/28/13. The patient is doing well having stopped using Norco 3 days ago, currently on Relafen bid, now sleeping well with good pain control. 5/31/13 note by [REDACTED] notes that the patient is doing well, on Norco and occasional valium. This note does not list any of the medications listed above. 5/21/13 office note only has valium and Norco for medications. 3/8/13 initial ortho consult has Norco, Valium, Sertraline for medications.

2/15/13 note by Dr. [REDACTED] only discusses Norco, valium #40 and Zoloft, and recommendation for a second opinion ortho evaluation.

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 Flurbiprofen:

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 MTUS (2009): § 9792.24.2. and the Chronic Pain Medical Treatment Guidelines, pgs. 111-113, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg.70, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that the use of non-steroidal anti-inflammatory drugs (NSAIDs) is recommended and appropriate in conditions including osteoarthritis of the shoulder. The medical records provided for review indicate that none of the treater's notes reflect prescription or discussion of this medication. However, given the employee's painful shoulder condition, this medication is appropriate to use. **The request for Flurbiprofen is medically necessary and appropriate.**

2) Regarding the request for Ketamine:

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 MTUS (2009): § 9792.24.2. and the Chronic Pain Medical Treatment Guidelines, pgs. 111-113, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Ketamine, pg.56 and pg.113, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that Ketamine is not recommended for chronic pain. Additionally, the Guidelines indicate that the medication is recommended for neuropathic pain. The medical records provided for review indicate the employee has chronic musculoskeletal shoulder pain and does not suffer from neuropathic pain. The medical records provided for review indicate that none of the treater's notes discuss this medication, rationale, or indication. Also, none of the notes in the medical records provided for review support a diagnosis of neuropathic pain. **The request for Ketamine is not medically necessary and appropriate.**

3) Regarding the request for Cyclobenzaprine:

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 MTUS (2009): § 9792.24.2. and the Chronic Pain Medical Treatment Guidelines, pgs. 111-113, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Cyclobenzaprine, pg. 64, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that Cyclobenzaprine is not recommended for chronic use in chronic pain employees. Additionally, the guidelines state, "Cyclobenzaprine is recommended for a short course of therapy." The medical records provided for review indicate that none of the reports talk about Cyclobenzaprine, and it cannot be concluded from review of the reports how this medication was used and for what reason. The medical records provided for review indicate the employee has a chronic shoulder pain condition for which this medication is being prescribed. **The request for Cyclobenzaprine is not medically necessary and appropriate.**

4) Regarding the request for Gabapentin (Neurontin):

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 MTUS (2009): § 9792.24.2. and the Chronic Pain Medical Treatment Guidelines, pgs. 111-113, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Gabapentin, pg.18, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines do not recommend the use of this medication for neuropathic pain. The medical records provided for review indicate that the employee has had two shoulder surgeries for rotator cuff, labral and arthritic problems. Additionally, the medical records provided for review indicate that there is no indication that the employee has neuropathic pain for which Neurontin can be indicated. The medical records provided for review indicate that none of the treaters' notes indicate Neurontin and it is unclear from the medical records provided for review why this medication is prescribed neither from reading of the notes nor from the list of diagnosis and the problems for which the employee is being treated for. **The request for Gabapentin is not medically necessary and appropriate.**

5) Regarding the request for Lidocaine & Prilocaine:

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 MTUS (2009): § 9792.24.2. and the Chronic Pain Medical Treatment Guidelines, pgs. 111-113, which are a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section CRPS medications, pgs. 37-38, which are part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that Lidocaine and Lidocaine patches can be used for Chronic Regional Pain Syndrome (CRPS) or neuropathic pain when other medications have been tried and failed. The medical records provided for review indicate that there is no documentation of CRPS or neuropathic pain evidenced in this employee. The medical records provided for review indicate that none of the treaters' notes discuss Lidocaine or Prilocaine and one cannot tell why this medication is being prescribed. Based on the employee's diagnosis and treatment rendered thus far, there is no evidence that this medication is indicated. **The request for Lidocaine and Prilocaine is not medically necessary and appropriate.**

6) Regarding the request for Lipoderm base:

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 MTUS (2009): § 9792.24.2. and the Chronic Pain Medical Treatment Guidelines, pgs. 111-113, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Lidoderm, pgs. 56-57, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that Lidoderm patches are recommended for neuropathic pain or peripheral pain after other medications have failed. The medical records provided for review indicate that there is no documentation to support that this employee has neuropathic pain. The medical records provided for review indicate that the employee suffers from chronic shoulder pain having undergone two arthroscopic operations. Lipoderm base nor patches are indicated in this employee. **The request for Lipoderm base 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

/ejf

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.