

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/21/2013

[REDACTED]

[REDACTED]

| | |
|---------------------------|--------------|
| Employee: | [REDACTED] |
| Claim Number: | [REDACTED] |
| Date of UR Decision: | 8/1/2013 |
| Date of Injury: | 4/25/2011 |
| IMR Application Received: | 8/5/2013 |
| MAXIMUS Case Number: | CM13-0007337 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for Flurcyclo/caps/lid, QTY: 120 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ketop/lidoc/cap/tram, QTY: 60 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 8/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/4/2013. 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 Flurcyclo/caps/lid, QTY: 120 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Ketop/lidoc/cap/tram, QTY: 60 **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 Texas and Oklahoma. 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 patient is a 34-year-old female that reported an injury on 04/25/2011, the mechanism of injury is unknown. The Primary Treating Physician's Progress Report dated 05/20/2013 reported the cervical discogram was noted to be positive at the level of C5-6 and moderate partial concordant pain with annular tear and leakage at the level of C6-7. The patient complains of constant cervical pain, chronic headaches, tension between the shoulders and migraines. The note states the patient has failed all conservative measures which include activity modification, physical therapy, pain management and 2 cervical epidural blocks. The physical exam noted generalized weakness and numbness in the bilateral shoulders, arms, and hands. Additionally, the note reported positive Hawkins and impingement signs, limited range of motion to bilateral shoulders. Furthermore, the note reported tenderness at the lateral epicondyle and positive Cozen's sign and pain with terminal flexion at bilateral elbows. Examination of the lumbar spine noted tenderness at the paravertebral muscles with spasm, pain with terminal motion, seated nerve root test is positive, and dysesthesia at L5-S1 dermatomes.

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 Flurcyclo/caps/lid, QTY: 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 Treatment Guidelines, pages 111-113, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 28, 111-112, Topical Analgesics, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The requested medications contains capsaicin and lidocaine. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. The medical records provided for review do not provide evidence of the employee's intolerance or lack of response to other treatments. **The request for flurcyclo/capsaicin/lidocaine, QTY: 120 is not medically necessary and appropriate.**

2) Regarding the request for Ketop/lidoc/cap/tram, QTY: 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 Treatment Guidelines, pages 111-113, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 28 Capsaicin topical, and pg.111-112, Topical Analgesics, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The requested medications contains capsaicin and lidocaine. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. The medical records provided for review do not provide evidence of the employee's intolerance or lack of response to other treatments. **The request for ketoprofen/lidocaine/capsaicin/tramadol, QTY: 60 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.