
Notice of Independent Medical Review Determination

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested Dendracin lotion, 120ml **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Ultram ER, 150 mg #30 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the requested Electromyogram/Nerve Conduction Studies (EMG/NCS), bilateral lower extremities **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/14/2013 disputing the Utilization Review Denial dated 4/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/27/2013. 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 requested Dendracin lotion, 120ml **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Ultram ER, 150 mg #30 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the requested Electromyogram/Nerve Conduction Studies (EMG/NCS), bilateral lower extremities **is 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 April 17, 2013

“Clinical summary: According to the Initial evaluation report dated 04/03/2013, by Dr. [REDACTED] MD, the patient presented with pain in the mid back, lower back, and left leg. The pain was associated with tingling, numbness and weakness in the left leg. The patient stated that his symptoms have been improving since the injury. The pain in his back was 50 percent of his pain, and the pain in his leg was 50 percent of his pain. The patient can walk three blocks before having to stop because of his pain. Examination of the lumbar spine revealed range of motion to forward flexion was, 45 degrees, extension was 20 degrees, and side bending was 25 degrees to the right and 25 degrees to the left. There was tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms. There was positive straight leg raise test in the seated and supine position. There was diminished sensation in the right L5 and S1 dermatomes of the lower extremities. The patient was diagnosed with Lumbar radiculitis and Lumbago.”

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 5/14/13)
- Utilization review determination (dated 4/17/13)
- Employee medical records from [REDACTED], DC (dated 1/16/13-4/15/13)

- Employee medical records from [REDACTED], MD (dated 4/3/13-4/30/13)
- Employee medical records from [REDACTED] (dated 3/13/13)
- Employee medical records from [REDACTED] (dated 4/5/13)
- Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 93-94, 105, 112-113

1) Regarding the request for Dendracin lotion, 120ml :

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 105,112-113, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 111, which is part of the Medical Treatment Utilization Schedule (MTUS), as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee developed sudden low back and left leg pain while lifting an estimated 200 pounds at work on 1/4/13. The medical records provided and reviewed indicate initial treatment was three days post injury in the emergency department, where oral analgesics were prescribed. Follow up care has included 21 chiropractic treatments with referral to a medical physician for continuing treatment. The medical record of 4/3/13 indicates the employee continues to experience low back pain with paresthesias, and a request was made for Dendracin Lotion, Ultram ER, and for EMG/NCS of the bilateral lower extremities. The employee is now more than six (6) months post injury and is not healing as anticipated, meeting the guidelines for chronic pain.

The Chronic Pain Treatment Guidelines recommend topical analgesics as an option for neuropathic pain when trials of antidepressants and anticonvulsants fail. The medical records provided for review do document neuropathic pain, but there is no documentation of prior or current use of any antidepressants or anticonvulsants. The Dendracin lotion, 120ml **is not medically necessary and appropriate.**

2) Regarding the request for Ultram ER, 150 mg #30:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 93-94, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical

Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 11, which is part of the Medical Treatment Utilization Schedule (MTUS), as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee developed sudden low back and left leg pain while lifting an estimated 200 pounds at work on 1/4/13. The medical records provided and reviewed indicate initial treatment was three days post injury in the emergency department, where oral analgesics were prescribed. Follow up care has included 21 chiropractic treatments with referral to a medical physician for continuing treatment. The medical record of 4/3/13 indicates the employee continues to experience low back pain with paresthesias, and a request was made for Dendracin Lotion, Ultram ER, and for EMG/NCS of the bilateral lower extremities. The employee is now more than six (6) months post injury and is not healing as anticipated, meeting the guidelines for chronic pain.

The Chronic Pain Medical Treatment Guidelines do not support the use of Tramadol as a first-line medication; however, under the Tramadol section, reference is made to both the "Opioid" section and the "Opioid for neuropathic pain" section of the Guidelines. The medical records provided for review indicate the employee has both neuropathic and nociceptive pain for which "opioids" may be used. MTUS does not require a patient fail muscle relaxants or NSAIDs prior to treating nociceptive pain; it states "in most cases, analgesic treatment should begin with acetaminophen, aspirin or NSAIDs". MTUS, does, however, require clinical judgment be used by the treating physician in selecting the medication for the individual. The medical records reviewed indicate Ultram ER has since been discontinued due to the side effects of headache, but the initial prescription for Ultram ER is consistent with MTUS guidelines. The Ultram ER, 150mg #30 is **medically necessary and appropriate.**

3) Regarding the request for Electromyogram/Nerve Conduction Studies (EMG/NCS), bilateral lower extremities:

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

The Claims Administrator based its decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 308-310, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee developed sudden low back and left leg pain while lifting an estimated 200 pounds at work on 1/4/13. The medical records provided and reviewed indicate initial treatment was three days post injury in the emergency department, where oral analgesics were prescribed. Follow up care has included 21 chiropractic treatments with referral to a medical physician for continuing treatment. The medical record of 4/3/13 indicates the employee continues to

experience low back pain with paresthesias, and a request was made for Dendracin Lotion, Ultram ER, and for EMG/NCS of the bilateral lower extremities.

ACOEM guidelines state electrodiagnostic study is not indicated for obvious radiculopathy. The MRI report provided for review indicates Left L5 radiculopathy might be apparent; however, the left S1 root may or may not be under tension. The imaging findings do not explain the right-sided loss of sensation in the right L5 and S1. An EMG/NCV of the bilateral lower extremities would evaluate for left or right L5 or S1 radiculopathy or polyneuropathy. The Electromyogram/Nerve Conduction Studies (EMG/NCS), bilateral lower extremities, **is 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
1515 Clay Street, 18th Floor
Oakland, CA 94612

/dl

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.



