MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 12/17/2013

Employee:	
Claim Number:	
Date of UR Decision:	6/5/2013
Date of Injury:	3/12/2013
IMR Application Received:	7/1/2013
MAXIMUS Case Number:	CM13-0000908

1) MAXIMUS Federal Services, Inc. has determined the request for **EMG studies of the lower extremities is medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **NCV studies of the lower extremities is medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **six (6) visits of aqua therapy is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **Ativan 1mg #30 is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request for **Amitramadol-DM 4/20/10% Ultracream #240gm is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the request for **Gabaketolido Gabapentin/Ketoprofen/Lidocaine 6/20/6.15 % cream #240gm is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/1/2013 disputing the Utilization Review Denial dated 6/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/2/2013. 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 **EMG studies of the lower extremities is medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **NCV studies of the lower extremities is medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **six (6) visits of aqua therapy is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **Ativan 1mg #30 is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request for **Amitramadol-DM 4/20/10% Ultracream #240gm is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the request for **Gabaketolido Gabapentin/Ketoprofen/Lidocaine 6/20/6.15 % cream #240gm 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, has a subspecialty in Interventional Spine 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 Independent Medical Review (IMR) application shows the patient was injured on 3/12/13 and is disputing the 6/03/13 Utilization Review (UR) decision. The 6/3/13 UR decision was a modification, they approved the lumbar MRI; denied the electromyography (EMG)/nerve conduction velocity (NCV) test of the bilateral lower extremities (BLE), denied aquatic therapy, approved Meloxicam, Approved Norco, Denied Ativan, denied amitramidol and gabaketolido cream.

This is a 44-year-old, who injured his back, neck, leg and shoulder on 3/12/13 when he fell down a stairway of about 8 steps . He went to the medical center and was given Vicodin, soma, an injection and PT. He came under the care of Dr. on 5/16/13, still with 9-10/10 low back pain and 5/10 pain in the shoulders, neck and left leg. The items for this IMR were requested by Dr. on the 5/16/13 visit.

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:

1) **Regarding the request for EMG studies of the lower extremities:**

   The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
   The Claims Administrator based its decision on the ACOEM Guidelines, 2nd Edition, Chapter 12 – Low Back Complaints, page 303, which is part of the MTUS.

   The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 303, which is part of the MTUS.

   Rationale for the Decision:
   The MTUS/ACOEM Guidelines indicate that electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The medical records provided for review indicate that the employee injured the lower back, among other regions, on 3/12/13, and by 5/16/13, the employee still had severe pain, rated 9-10/10. The employee's low back symptoms have lasted more than 3-4 weeks. **The request for EMG studies of the lower extremities is medically necessary and appropriate.**

2) **Regarding the request for NCV studies of the lower extremities:**

   The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
   The Claims Administrator based its decision on the ACOEM Guidelines, 2nd Edition, Chapter 12 – Low Back Complaints, page 303, which is part of the MTUS. The Claims Administrator also cited the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Ankle and Foot Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 14) pg. 303, which is part of the MTUS. The Expert Reviewer also cited the the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 303, which is part of the MTUS.

Rationale for the Decision:
The MTUS/ACOEM Guidelines indicate electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The guidelines also indicate that peripheral neuropathy may present with decreased sensation in the foot or ankle. The use of nerve conduction testing is appropriate for evaluating peripheral neuropathy. The medical records provided for review indicate that the treating provider stated that there are symptoms of radiculopathy, with numbness and tingling down the leg to the foot in the L5 and S1 distribution, but he wanted to rule out peripheral neuropathy. The request meets guideline criteria. **The request for NCV studies of the lower extremities is medically necessary and appropriate**.

3) **Regarding the request for six (6) visits of aqua therapy :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Aquatic Therapy and Physical Medicine, pages 22, and 98-99, which is part of the MTUS.

Rationale for the Decision:
The Chronic Pain Guidelines recommend aquatic therapy as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. The guidelines also indicate that 8-10 sessions of physical therapy (PT) are recommended for various myalgias and neuralgias. The medical records provided for review indicate that the employee has been going through PT and had 12 visits from 4/18/13 through 6/11/13 with no change in function or pain, specifically, no improvement in back mobility, sitting, standing, sleeping, pain levels, lifting or walking. The employee has already exceeded the number of PT sessions. **The request for six (6) visits of aqua therapy is not medically necessary and appropriate.**

4) **Regarding the request for Ativan 1mg #30:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, page 24, which is part of the MTUS.

Rationale for the Decision:
The Chronic Pain Guidelines indicate that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence, and limits use to 4 weeks. The medical records provided for review do not provide enough information to determine if the Ativan dosing is in accordance with the recommended dosing listed under the MTUS guidelines, or other review standards. **The request for Ativan 1mg #30 is not medically necessary and appropriate.**

5) **Regarding the request for Amitramadol-DM 4/20/10% Ultracream #240gm:**
The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the ACOEM Guidelines, 2nd Edition, Chapter 3 – Initial Approaches to Treatment, page 49, Table 3-1 Summary of Recommendations on Initial Approaches to Treatment, which is 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 for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical records provided for review do not indicate the employee had trials of antidepressants or anticonvulsants. **The request for Amitramadol-DM 4/20/10% Ultracream #240gm is not medically necessary and appropriate**.

6) **Regarding the request for Gabaketolido Gabapentin/Ketoprofen/Lidocaine 6/20/6.15 % cream #240gm:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the ACOEM Guidelines, 2nd Edition, Chapter 3 – Initial Approaches to Treatment, page 49, Table 3-1 Summary of Recommendations on Initial Approaches to Treatment, which is 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 for neuropathic pain when trials of antidepressants and anticonvulsants have failed, and that if a compound medication that contains one component that is not recommended, then the whole compound medication is not recommended. The guidelines also indicate that gabapentin is not recommended as a topical analgesic, and Ketoprofen is not recommended because the FDA has not approved it for topical applications. The guidelines do not support the use of Lidoderm patches. The medical records provided for review do not indicate the employee had trials of antidepressants or anticonvulsants. The request does not meet guideline criteria. **The request for Gabaketolido Gabapentin/Ketoprofen/Lidocaine 6/20/6.15 % cream #240gm 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.