

Independent Medical Review Final Determination Letter

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[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/27/2013

IMR Case Number:	CM13-0017430	Date of Injury:	02/01/2006
Claims Number:	[REDACTED]	UR Denial Date:	08/19/2013
Priority:	STANDARD	Application Received:	08/28/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] DO		
Treatment(s) in Dispute Listed on IMR Application:			
CHIROPRACTIC CARE 2 X 6 KNEE, LUMBAR SPINE AND ANKLE / NOT MEDICALLY CERTIFIED BY PHYSICIAN ADVISOR 240GM COMPOUND (CAPSAICIN 0.025%, FLUBIPROFEN 30%, METHYL SALICYLATE 4%) NOT MEDICALLY CERTIFIED BY PHYSICIAN ADVISOR 240GM COMPUND (FKYRBUORIFEB 20%,			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]
[REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in North Carolina, New York, and Pennsylvania. 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant is a 70 year old woman with bilateral knee pain, right ankle pain, left hip pain and low back pain after a slip and fall at work 11/22/1996 on a slippery floor, with her injuries becoming unbearable by 2/1/2006. Some records state that she sustained an ankle fracture when she fell. She sought treatment many years after the alleged injury. She is diagnosed with right ankle sprain/strain, plantar fasciitis, lumbar disc derangement without myelopathy, and internal derangement of the knees (meniscal). She has had physical therapy and medical management, which were helpful. The claimant had consultation with pain management. She has had left knee arthroscopic surgery in 1999. She uses lumbar support, narcotic medications (Norco, Tramadol), TENS unit. She has had lumbar MRI, showing multilevel degenerative changes, She is noted to have a left leg neuropathy "from chemotherapy" and had neurodiagnostic testing in October 2012 showing diabetic polyneuropathy and L5-S1 radiculopathy. MRI of the knee revealed advance arthritic changes, worse in the left knee compared to the right.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. chiropractic care for two times per week for six weeks for the lumbar spine and ankle is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Guidelines, Manual therapy & manipulation, page 58, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Guidelines, Manual therapy & manipulation, page 58, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The reviewed records do not indicate that the pain is caused by a musculoskeletal condition, but does indicate multilevel degenerative changes. The MTUS guidelines do not recommend manipulative treatment for the ankle. **The request for chiropractic care for two times per week for six weeks for the lumbar spine and ankle is not medically necessary and appropriate.**

2. 240 gm compound (Capsaicin 0.025%, Flurbiprofen 30%, Methyl Salicylate 4% is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-112, which is part of the MTUS.

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

The Physician Reviewer's decision rationale:

Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Clinical trials have shown variability in efficacy of topical NSAIDs, per the Chronic Pain Medical Treatment Guidelines. Topical NSAIDs are recommended for knee, elbow or other joints amenable to topical treatment for osteoarthritis and tendonitis. Topical Voltaren Gel is what is recommended, and FDA-approved. Flurbiprofen is not included in the recommendations. For a compound to be approved, all components must be approved, so this request does not meet criteria under the MTUS Guidelines. **The request for 240 gm compound (Capsaicin 0.025%, Flurbiprofen 30%, Methyl Salicylate 4% is not medically necessary and appropriate.**

3. 240 gm compound (Flurbiprofen 20%, Tramadol 20%) is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-112, which is part of the MTUS.

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

The Physician Reviewer's decision rationale:

Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Clinical trials have shown variability in efficacy of topical NSAIDs, per the Chronic Pain Medical Treatment Guidelines. Topical NSAIDs

are recommended for knee, elbow or other joints amenable to topical treatment for osteoarthritis and tendonitis. Topical Voltaren Gel is what is recommended, and FDA-approved. Flurbiprofen is not included in the recommendations. Tramadol is not listed as a topical agent that is recommended in the Chronic Pain Guidelines. For a compound to be approved, all components must be approved, so this request does not meet criteria for approval under the MTUS Guidelines. **The request for 240 gm compound (Flurbiprofen 20%, Tramadol 20%) is not medically necessary and appropriate.**

4. 30% Medrox patch is not medically necessary and appropriate.

The Claims Administrator based its decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3) pages 47-48, which is part of the MTUS, and dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid...?, Medrox-methyl Salicylate, menthol and capsaicin patch., which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-112, and 105, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Medrox is a combination of methyl salicylate, capsaicin and menthol. Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. Salicylate topicals are recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. Menthol is NOT mentioned in the chronic treatment guidelines. For a compound to be approved, all components must be approved, so this request does not meet criteria under the MTUS guidelines. **The request for 30% Medrox patch is not medically necessary and appropriate.**

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.

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