

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 12/3/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	12/17/2002
IMR Application Received:	8/6/2013
MAXIMUS Case Number:	CM13-0007441

- 1) MAXIMUS Federal Services, Inc. has determined the request for Dendracin topical lotion 120 ml **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for chiropractic treatment - 10 visits two (2) times a week for five (5) weeks **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for chiropractic physiotherapy - one (1) time a week for six (6) weeks **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/5/2013. 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 Dendracin topical lotion 120 ml **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for chiropractic treatment - 10 visits two (2) times a week for five (5) weeks **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for chiropractic physiotherapy - one (1) time a week for six (6) weeks **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 Illinois, Indiana, Texas. 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 45-year-old who reported injury on 12/17/2012. The patient was noted to have pain that was rated a 7. The patient was noted to have cervical spine range of motion that was full in all planes. The patient was noted to have tenderness to palpation of the bilateral lumbar paraspinal muscles consistent with spasms. The diagnosis was stated to be displacement of lumbar intervertebral disc without myelopathy. The treatment plan was noted to be Dendracin topical lotion 120 mL, chiropractic treatment 10 visits 2 times a week for 5 weeks, and chiropractic physiotherapy 1 time a week for 6 weeks.

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 Dendracin topical lotion 120 ml:

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 Medical Treatment Guidelines, Topical Analgesics, and NSAIDs, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, salicylate topicals, pgs. 105 and 111, which are part of the MTUS, and Drugs.com, (<http://www.drugs.com/search.php?searchterm=Dendracin>) which is not part of the MTUS.

Rationale for the Decision:

CA MTUS Guidelines recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. According to Drugs.com the ingredients for Dendracin lotion are a combination of methylsalicylate, benzocaine, and menthol used for the temporary relief of minor aches and pains caused by arthritis, simple backaches, and strains. Additionally, CA MTUS Guidelines recommends salicylate topicals for pain. The examination noted the employee complained of pain in the lower back with radiation to the right leg with associated tingling and weakness in the legs and numbness in the feet. The pain was noted to be usually frequent in frequency but was noted to constant as of the note 07/11/2013. Clinical documentation submitted for review failed to show that the employee had a trial of antidepressants and anticonvulsant and failed to provide the efficacy of the requested medication. **The request for Dendracin topical lotion 120 ml is not medically necessary and appropriate.**

2) Regarding the request for chiropractic treatment - 10 visits two (2) times a week for five (5) weeks:

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 Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy, pgs. 58-59, which are part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines recommend extended durations of care beyond the maximum of 8 weeks should include documented objective improvement in function. It was noted that the employee had tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms and sciatic notch tenderness along with positive lumbar facet loading and a positive straight leg raise on the right in the seated and supine positions up to 50 degrees.

The employee was noted to have sacroiliac joint tenderness on the right. The employee stated that chiropractic physiotherapy was the only treatment of any benefit to reduce pain and improve function. **The request for chiropractic treatment - 10 visits two (2) times a week for five (5) weeks is not medically necessary and appropriate.**

3) Regarding the request for chiropractic physiotherapy - one (1) time a week for six (6) weeks:

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 Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy, pgs. 58-59, which are part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines recommend extended durations of care beyond the maximum of 8 weeks should include documented objective improvement in function. It was noted that the employee had tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms and sciatic notch tenderness along with positive lumbar facet loading and a positive straight leg raise on the right in the seated and supine positions up to 50 degrees. The employee was noted to have sacroiliac joint tenderness on the right. The employee stated that chiropractic physiotherapy was the only treatment of any benefit to reduce pain and improve function. However, this request is duplicative of #2 and as such is not medically necessary. **The request for chiropractic physiotherapy - one (1) time a week for six (6) weeks is not medically necessary or 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.