

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

December 20, 2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/31/2013  
Date of Injury: 2/20/1998  
IMR Application Received: 8/15/2013  
MAXIMUS Case Number: CM13-0012045

Dear Mr./Ms. [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]

## 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 Physical Medicine & Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in Ohio and 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 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 patient is a 51-year-old female who sustained work-related injuries on 11/12/1994 and 02/20/1998. A progress report by Dr. [REDACTED] dated 02/22/2013 indicated physical examination findings of a tender right subacromial space and lower back. The treatment plan at that time included refills of Zanaflex, Prilosec, and Lidoderm patches. A progress report by Dr. [REDACTED] dated 06/28/2013 noted patient complaints of right shoulder, right knee, and lower back pain. Objective findings again revealed tenderness of the right subacromial space and lower back pain. The treatment plan included refill of Norco, Zanaflex, Prilosec, Lidoderm patches, and Ketoprofen gel. The most recent progress report dated 08/21/2013 by Dr. [REDACTED] noted patient complaints of continued right shoulder, right knee, and lower back pain. Objective findings were noted as tenderness to the right subacromial space and lower back. The treatment plan at that time included refill of Norco, Zanaflex, Prilosec, Lidoderm patches, and Ketoprofen gel.

### IMR DECISION(S) AND RATIONALE(S)

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

#### **1. Zanaflex 4mg bid #60 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle Relaxants, page 63, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS Guidelines recommend the use of non-sedating muscle relaxants with caution in the management of spasticity as a second line option for short-term treatment of acute exacerbations in patients with chronic lower back pain. Additionally, the efficacy of muscle relaxants appears to diminish over time. In the clinical information provided for review, there is no documentation of muscle spasm noted upon examination. Therefore, based on the lack of documentation that supports the criteria for use of muscle relaxants and without clear indication for use, medical necessity for Zanaflex is not established. **The request for Zanaflex 4 mg 2 times a day #60 is not medically necessary and appropriate.**

## **2. Lidoderm patches #60 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Lidoderm, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Lidoderm, pages 56-57, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS Guidelines recommend the use of Lidoderm for localized peripheral pain after there has been evidence of a trial of first line therapy such as tricyclics, SNRI anti-depressant, or an AED such as gabapentin or Lyrica. Furthermore, Lidoderm is only FDA approved for postherpetic neuralgia. Guidelines indicate further research is needed to recommend this treatment for chronic neuropathic pain disorders. In the clinical information submitted for review, there is no documentation provided that the employee's condition is neurogenic in origin. Furthermore, there is no documentation provided as to Lidoderm's efficacy for the employee's reports of pain. **The request for Lidoderm patches #60 is not medically necessary and appropriate.**

## **3. Ketoprofen gel 120ml. is not medically necessary and appropriate.**

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

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

The Physician Reviewer's decision rationale:

Given the lack of clear indication for use and the fact that Ketoprofen is not FDA approved as a topical application, medical necessity is not established. **The request for Ketoprofen gel 120 mL 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.



[REDACTED]

CM13-0012045