

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/8/2013
Date of Injury:	9/22/2010
IMR Application Received:	8/16/2013
MAXIMUS Case Number:	CM13-0012290

- 1) MAXIMUS Federal Services, Inc. has determined the request for **compounded topical cream (Ketoprofen%/Lidocaine10%/Baclofen10%) 180GM, thirty day supply, #180 with no refills is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/16/2013 disputing the Utilization Review Denial dated 8/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/24/2013. 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 **compounded topical cream (Ketoprofen%/Lidocaine10%/Baclofen10%) 180GM, thirty day supply, #180 with no refills** 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 Family Practice, 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 patient is a 62-year-old male who reported an injury on 09/22/2010. The patient continued to complain of chronic pain in his lumbar spine and left knee. He was noted to also be suffering with morbid obesity. The patient is noted to have spasm and tenderness in the paravertebral muscles of the lumbar spine with decreased range of motion on flexion and extension with discomfort on flexion and extension of the left knee against gravity. The clinical note dated 04/25/2013 reported the patient continued to have lumbar spine pain radiating to the lower extremities with pain, paresthesia, and numbness in the bilateral lower extremities. The patient is noted to have spasm, tenderness, and guarding in the paravertebral musculature of the lumbar spine with loss of range of motion and decreased sensation bilaterally in the S1 dermatome. The patient is noted to have treated with cortisone injections to the right knee, acupuncture treatments, which provided him temporary relief. On that date, the patient is noted to be taking Vicodin. The patient is noted to have been prescribed a compounded cream containing ketoprofen, lidocaine, and baclofen.

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 the Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for compounded topical cream (Ketoprofen%/Lidocaine10%/Baclofen10%) 180GM, thirty day supply, #180 with no refills:

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 CA Medical Treatment Utilization Schedule 2009: Chronic Pain Treatment Guidelines, Pgs. 111-113: Topical Analgesics, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, Pgs. 111-113, which is part of the MTUS.

Rationale for the Decision:

The medical records submitted for review indicate the employee reported an injury to the employee's left ankle on 09/22/2010. The employee is noted after injuring the employee's left ankle to have developed left knee and hip pain, and then right low back pain, and then right lower extremity pain. The employee is noted to have no muscle spasms, no tenderness to palpation of the lumbar spine, patellar crepitus and tenderness noted with firm compression of the bilateral knees, medial and lateral joint line tenderness, and positive McMurray's sign bilaterally. The employee is noted to have tenderness over the anterior talofibular ligament and peroneal tendons bilaterally. The employee had been prescribed a compounded topical cream containing ketoprofen, lidocaine, and baclofen. The California MTUS Guidelines state ketoprofen is not approved by the FDA as a topical application as there is extremely high incidence of photocontact dermatitis and also states no other commercial approved topical formulation of lidocaine, whether cream, lotions, or gels, is recommended for neuropathic pain. It states that baclofen is not recommended for treatment, as there is no peer-reviewed literature to support the use of topical baclofen. The guidelines also state that any compounded product that contains at least one drug, or drug class that is not recommended, is not recommended. As ketoprofen, lidocaine, and baclofen are not recommended for topical use, the requested compounded topical cream does not meet guideline recommendations. **The request for compounded topical cream (Ketoprofen%/Lidocaine10%/Baclofen10%) 180GM, thirty day supply, #180 with no refills 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.