

## Independent Medical Review Final Determination Letter

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Dated: 12/18/2013

<b>IMR Case Number:</b>	CM13-0017563	<b>Date of Injury:</b>	11/10/2000
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/14/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/28/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED]		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

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]

## 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 Internal Medicine and is licensed to practice in New York. 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from the Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

### 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 41 year-old male with date of injury of 11/10/2000. Diagnoses include lumbar disc extrusion, lumbar disc disease, lumbar radiculopathy, lumbar facet joint pain, and sacroiliac pain. Pain is described as severe, sharp, and stabbing and is exacerbated with sitting, twisting, and rising from a chair. Treatment has included medical therapy, heat therapy, and physical therapy. The exam reveals lumbosacral tenderness, positive straight leg raising, mild motor weakness in the right lower extremity, and decreased lumbar range of motion. MRI of the lumbar spine dated 2010 demonstrated L5-S1 disc extrusion. The treating provider has recommended use of a topical compound cream which contains Ketoprofen, Flurbiprofen, and Tramadol.

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

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

#### **1. Ketoprofen/Flurbiprofen/Tramadol compound cream is not medically necessary and appropriate.**

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

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

The Physician Reviewer's decision rationale:

A review of the records indicates that there is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control ( including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, GABA agonists, prostaglandins, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug ( or drug class) that is not recommended is not recommended. In this case Ketoprofen is not FDA approved for a topical application and the NSAID, Flurbiprofen is a topical NSAID that has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either not afterward, or with diminishing effect over another two-week period. There is lack of scientific evidence to support the use of topical Tramadol. **The request for Ketoprofen/Flurbiprofen/Tramadol compound cream 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]

CM13-0017563