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**Notice of Independent Medical Review Determination**

Dated: 10/2/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/3/2013  
Date of Injury: 7/23/1971  
IMR Application Received: 7/16/2013  
MAXIMUS Case Number: CM13-0001688

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of Pennsaid 1.5% Solution (Cypress Care) **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/18/2013. 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 1 prescription of Pennsaid 1.5% Solution (Cypress Care) **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 Occupational Medicine, 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.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013:

“The patient is a 66 year old male with a date of injury of 7/23/1971. The provider is requesting prospective certification for prescription of Pennsaid.

“According to the documentation, the patient has been receiving care for neck, left shoulder, and low back pain. Treatment has consisted of analgesics, muscle relaxants, opioid medications, and Pennsaid, The narrative report from 6/26/2013 by [REDACTED], DO states that the patient was continuing to experience neck, left shoulder, and low back pain. Significant examination findings included reduced cervical spine range of motion, neck tenderness, trigger points, positive Spurling's tests bilaterally, normal motor strength, normal reflexes, intact sensation, decreased lumbar spine range of motion, and low back tenderness.

“Regarding the request for Pennsaid, the evidence-based guidelines recommend the use of topical non-steroidal anti-inflammatory drugs (NSAIDs) for the short-term treatment of osteoarthritis and tendinitis of the knee or elbow. The guidelines state that there is little evidence for the use of topical NSAIDs in the treatment of osteoarthritis of the spine, hip, or shoulder, and topical NSAID's are not recommended for the treatment of neuropathic pain.

“According to the narrative report on 6/26/2013, the patient was continuing to experience neck, left shoulder, and low back pain. The documentation indicates that a prescription for a 30 day supply of Pennsaid was previously certified in review 373418 on 5/23/2013. Overall, the documentation does not demonstrate that the trial of Pennsaid was effective in relieving pain or improving function, and the evidence-based

guidelines only recommend topical NSAIDs for the short-term treatment of chronic musculoskeletal pain. Further, the guidelines state that there is little evidence supporting the use of topical NSAIDs for the treatment of neck, shoulder, and low back pain. Considering the clinical findings, the patient's response to the trial of Pennsaid, and the guidelines cited, additional Pennsaid is not medically indicated. Therefore, the request for one prescription of Pennsaid 1.5% Solution (Cypress Care) is recommended non-certified.”

**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 for Independent Medical Review (received 7/16/13)
- Utilization Review Determination (dated 7/3/13)
- California Medical Treatment Utilization Schedule (MTUS)
- Medical Records from Claims Administrator

**1) Regarding the request for 1 prescription of Pennsaid 1.5% Solution (Cypress Care):**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 7/31/1971 and has been receiving care for neck, left shoulder, and low back pain. Treatment has included analgesics, muscle relaxants, opioid medication, and Pennsaid. The request is for 1 prescription of Pennsaid 1.5% Solution (Cypress Care).

The MTUS Chronic Pain Guidelines recommend Pennsaid for the knee or elbow, and only for a limited time. There is no data to suggest that topical non-steroidal anti-inflammatory drugs help with lumbar or cervical pain, or with neuropathic pain. The medical records provided for review indicate that the employee has tried this medication for a month without functional improvement and it is being used on part(s) of the body that are not recommended by the guideline. The request for 1 prescription of Pennsaid 1.5% Solution (Cypress Care) **is not medically necessary and 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;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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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.