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**Notice of Independent Medical Review Determination**

Dated: 10/8/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/5/2013

12/19/2012

7/18/2013

CM13-0002003

- 1) MAXIMUS Federal Services, Inc. has determined the request for Compound analgesic med: Ketoprofen 10%/ Gabapentin 10%/ Lidocaine 10% **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 Compound analgesic med: Ketoprofen 10%/ Gabapentin 10%/ Lidocaine 10% **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, has a subspecialty in Internal Medicine, Orthopedic Surgery & Toxicology 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 5, 2013

“According to the records made available for review, this is a 40-year-old female patient, s/p injury 12/19/12. The patient most recently (5/14/13) presented with neck pain radiating into the head. Physical examination revealed decreased C/S ROM. Current diagnoses include C/S central disc extrusion and bilateral upper extremity radicular pain. Treatment to date includes medications. Treatment requested is compound analgesic med: Ketoprofen 10% Gabapentin 10% Lidocaine 10%.”

### **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 07/18/2013)
- Utilization Review Determination from [REDACTED] (dated 07/05/2013)
- Employee Medical records from Claims Administrator
- Medical Treatment Utilization Schedule

### **1) Regarding the request for Compound analgesic med: Ketoprofen 10%/ Gabapentin 10%/ Lidocaine 10% :**

#### 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) pg. 111-113 which is part of the 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 December 19, 2012 to the neck and bilateral upper extremities. Treatments have included acupuncture, chiropractic manipulative therapy, and medication management. The request is for Compound analgesic medications: Ketoprofen 10%, Gabapentin 10%, Lidocaine 10%.

The MTUS Chronic Pain Treatment Guidelines state that topical analgesics and topical compounds are largely experimental, and are recommended in case of neuropathic pain in which antidepressants and/or anticonvulsants have been tried and failed. Also, when one ingredient in a topical compound is not endorsed, the entire compound is considered not recommended. In this case, two of the ingredients in the topical compound, specifically ketoprofen and gabapentin, are not recommended or endorsed for topical use purposes. Therefore, the request for compound analgesic medications: Ketoprofen 10%, Gabapentin 10%, Lidocaine 10% 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  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

/hs

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.