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**Notice of Independent Medical Review Determination**

Dated: 11/26/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 5/22/2013  
Date of Injury: 1/23/2010  
IMR Application Received: 7/22/2013  
MAXIMUS Case Number: CM13-0002533

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Ketoprofen 20% gel 60 grams, one refill is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Zanaflex 1 mg #90, one refill is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Prilosec 20 mg #30, one refill is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 5/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 Ketoprofen 20% gel 60 grams, one refill **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Zanaflex 1 mg #90, one refill **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20 mg #30, one refill **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.

### **Expert Reviewer Case Summary:**

The claimant is a 50 year old male with date of injury 1/23/2010, diagnosed with chronic regional pain syndrome, ulnar nerve neuropathy, median nerve neuropathy, radial nerve neuropathy, and status post closed reduction internal fixation of right thumb fracture 2/2010.

### **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
- Utilization Review Determination from Claims Administrator
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for Ketoprofen 20% gel 60 grams, one refill:**

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

The Claims Administrator based its decision on the CA MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-112, which are part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines indicate that Ketoprofen is not FDA approved for topical use, and has an extremely high incidence of photosensitivity. The thumb is an area of the body that is usually exposed to sunlight. The guidelines do not support the use of this medication for this employee. **The request for Ketoprofen 20% gel 60 grams, one refill is not medically necessary and appropriate.**

**2) Regarding the request for Zanaflex 1 mg #90, one refill:**

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

The Claims Administrator based its decision on the CA MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 63-64, which are part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines indicate that the use of muscle relaxants is only recommended by the guidelines for short term use, in the case of an acute exacerbation of pain due to spasticity. The records submitted and reviewed indicate the employee has been using Zanaflex since at least March 2013 and there is no documented improvement in symptoms with the use of Zanaflex. In addition, the requested use of Zanaflex is not consistent with the uses supported in the guidelines, because the employee's condition is not related to low back pain. **The request for Zanaflex 1 mg #90, one refill is not medically necessary and appropriate.**

**3) Regarding the request for Prilosec 20 mg #30, one refill:**

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

The Claims Administrator based its decision on the CA MTUS.

The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, (2009), NSAIDs, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines indicate that a proton pump inhibitor (PPI) is often used in conjunction with the use of non-steroidal anti-

inflammatory drugs (NSAIDs) to provide gastrointestinal protection. The employee was prescribed Ketoprofen topical, and prescribing a PPI with this medication is appropriate. However, the request for Ketoprofen topical was determined to be not medically necessary. There is also no evidence that the employee is currently using NSAIDs, although the employee was previously taking ibuprofen. There is a lack of documentation of an indication for the requested medication. **The request for Prilosec 20 mg #30, one refill 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;

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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