

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/18/2013

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/11/2013
Date of Injury:	1/22/2010
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003351

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for Terocin lotion **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for Ketoprofen (NAP) cream 180gm **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for Ketogabacyclo, penderm base 180gm **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 retrospective request for Terocin lotion **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for Ketoprofen (NAP) cream 180gm **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for Ketogabacyclo, penderm base 180gm **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 Physical Medicine and Rehabilitation, 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 11, 2013:

PT evaluation and certification note dated 06/03/13 indicates the claimant exhibited decline in all aspects of functional mobility due to limited bilateral lower extremities muscle strength/range of motion, dynamic balance, postural control, and functional activity tolerance. The claimant also complains of severe left hip pain upon rest and increases with activities even when premedicated resulting to increase assistance needed. Provider recommends skilled physical therapy services.

OT evaluation and certification note dated 06/03/13 indicates the claimant displays decreased in strength, functional mobility, transfers, range of motion, ambulation, balance, postural alignment, and activities of daily living and pain indicating the need for

physical therapy to increase safety with activities of daily living. Examination reveals decreased range of motion and muscle testing, pain at left hip area rated 8/10 at rest and 10/10 with movement, fair balance, impaired skin integrity in the left hip incision site, antalgic gait, abnormal posture, and use of front wheeled walker. Provider recommends skilled occupational therapy services.

History and physical report dated 06/07/13 indicates that the claimant is status post left total hip replacement. The claimant presents for rehabilitation. The claimant is allergic to Tetracycline. Medication includes Norco for severe pain. Examination reveals pain in the genito-urinary, bones and joints. The rest of the handwritten file is illegible.

Review of claim notes that hips and heart are accepted.

### **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 7/25/13)
- Utilization Review Determination from [REDACTED] (dated 7/11/13)
- Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the retrospective request for Terocin lotion:**

##### 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, 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 was injured on 1/22/2010 and has experienced left hip pain. Diagnoses include bilateral hip avascular necrosis, lumbar spine sprain/strain, and bilateral lower extremity radiculitis. The retrospective request is for Terocin lotion.

The MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The medical records submitted and reviewed did not show any failed trials of these types of medications. The guideline criteria are not met. The retrospective request for Terocin lotion **is not medically necessary and appropriate.**

**2) Regarding the retrospective request for Ketoprofen (NAP) cream 180gm:**

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, 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 Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, pg. 111, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 1/22/2010 and has experienced left hip pain. Diagnoses include bilateral hip avascular necrosis, lumbar spine sprain/strain, and bilateral lower extremity radiculitis. The retrospective request is for Ketoprofen (NAP) cream 180gm.

The MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The medical records submitted and reviewed did not show any failed trials of these types of medications. The guideline criteria are not met. The retrospective request for Ketoprofen (NAP) cream 180gm **is not medically necessary and appropriate.**

**3) Regarding the retrospective request for Ketogabaclo, penderm base 180gm:**

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, 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 Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, pg. 111, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 1/22/2010 and has experienced left hip pain. Diagnoses include bilateral hip avascular necrosis, lumbar spine sprain/strain, and bilateral lower extremity radiculitis. The retrospective request is for Ketogabaclo, penderm base 180gm.

The MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not

recommended. The medical records submitted and reviewed did not show any failed trials of these types of medications. The guideline criteria are not met. The retrospective request for Ketogabacyclo, penderm base 180gm **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

/ldh

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.