

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/28/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/9/2013
Date of Injury: 6/11/2012
IMR Application Received: 8/1/2013
MAXIMUS Case Number: CM13-0005621

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 Orthopedic Surgery 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 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:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This claimant is a 63-year-old female who was injured in a work-related accident June 11, 2012. Recent clinical assessment indicates that the claimant fell injuring her right foot with secondary complaints of left elbow and left knee pain. This individual was injured while working as a legal secretary. The last report was dated June 3, 2013 where the claimant was seen for complaints of neck pain with radiating muscle spasm and discomfort to the bilateral upper extremities, low back pain with burning and radicular pain and spasm to the lower extremities, bilateral knee complaints with spasm, and right foot and ankle pain with spasm. Physical examination showed the cervical spine to be with tenderness to palpation in the trapezius and levator muscles with diminished range of motion at endpoints, diminished motor strength at 4/5 to all major muscle groups of the bilateral upper extremities, and equal and symmetrical +2 reflexes. Lumbar evaluation showed restricted range of motion with positive straight leg raising and antalgic gait and restricted range of motion from 0 to 120 degrees of the bilateral knees with positive patellar compression and Apley's testing. The right ankle and foot examination showed tenderness to palpation over the plantar fascia with normal heel and toe walking. The claimant's diagnoses were as follows: (1) cervicgia, (2) cervical radiculopathy, (3) lumbago, (4) lumbar radiculopathy, (5) bilateral knee pain, (6) bilateral knee internal derangement, and (7) right foot plantar fasciitis. There were requests for medications at that time to include the following: (1) topical ketoprofen 20%, (2) topical Cyclophene 5%, (3) Synapryn 20 mg oral suspension, (4) Tabradol 1mg suspension, (5) Deprizine 5 mg suspension, and (6) Dicopanil 5 mg suspension.

IMR DECISION(S) AND RATIONALE(S)

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

1. Decision for Ketoprofen 20% in PLO Gel 120 gm three times a day, QTY 1.00 is not medically necessary and appropriate.

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

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

The Physician Reviewer's decision rationale:

The MTUS chronic pain guidelines indicate that there is no peer-reviewed literature to support the topical use of Baclofen or other muscle relaxants. The requested topical in this case contains cyclobenzaprine, a muscle relaxant, therefore, it cannot be recommended as medically necessary. **The request for Ketofen 20% in PLO Gel 120 gm three times a day, QTY 1.00 is not medically necessary and appropriate.**

2. Cyclophene 5% in PLO Gel gm three times a day, QTY: 1:00 is not medically necessary and appropriate.

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

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

The Physician Reviewer's decision rationale:

The MTUS chronic pain guidelines indicate that there is no peer-reviewed literature to support the topical use of Baclofen or other muscle relaxants. The requested topical in this case contains cyclobenzaprine, a muscle relaxant; therefore, it cannot be recommended as medically necessary. **The request for Cyclophene 5% PLO Gel gm three times a day, QTY:1:00 is not medically necessary and appropriate.**

3. Synapryn 20 mg/1 ml Oral Suspension 500 ml twice a day, QTY: 1.00 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of MTUS.

The Physician Reviewer based his/her decision on the the Chronic Pain Medical Treatment Guidelines, pg. 7, which is part of MTUS.

The Physician Reviewer's decision rationale:

The use of this non-narcotic analgesic would not be supported for chronic or long-term use given the employee's current diagnosis and clinical presentation. Additionally, the MTUS guidelines indicate that the choice of pharmacotherapy should be made giving consideration to the individual's specific variables. In this case it is not clear as to why this employee would be required to take any of their prescribed medications in the form of a suspension. **The request for Synapryn 20 mg/ml Oral Suspension 500 ml twice a day, QTY: 1.00 is not medically necessary and appropriate.**

4. Tabradol 1mg/ml Oral Suspension 250 ml twice to three times a day, QTY: 1.00 is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Chronic Pain,, pgs.41-42, which is part of MTUS.

The Physician Reviewer's decision rationale:

Tabradol is a muscle relaxant, which would not be indicated for long-term use. The MTUS guidelines only recommend the role of short-term use of muscle relaxants. In the chronic setting, they are not preferred. Additionally, the MTUS guidelines indicate that the choice of pharmacotherapy should be made giving consideration to patient specific variables. In this case it is not clear as to why this employee would be required to take any of their prescribed medications in the form of a suspension. Continued use at this time would not be indicated. **The request for Tabradol 1mg/ml Oral Suspension 250 ml twice to three times a day, QTY: 1.00 is not medically necessary and appropriate.**

5. Deprizine 5mg/ ml 250 ml Oral Suspension once a day, QTY:1.00 is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Chronic Pain, which is part of MTUS.

The Physician Reviewer's decision rationale:

According to the MTUS Guidelines, the role of Deprizine, a gastrointestinal (GI) protective agent, would not be indicated as this employee does not meet GI risk factors to support use with medications at present. There is no indication of an age greater than 65 years old, history of peptic ulcer, GI bleeding or perforation, concordant use of aspirin with corticosteroids or anti-coagulants or high-dose multiple nonsteroidal usage. **The request for Deprizine 5mg/ ml 250 ml Oral Suspension once a day, QTY:1.00 is not medically necessary and appropriate.**

6. Dicapanol 5mg/ml Oral Suspension 150 ml at bedtime, QTY: 1.00 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines Treatment (ODG), which is not part of MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Section Treatment in Worker's Comp , 18th Edition, 2013, which is not part of MTUS

The Physician Reviewer's decision rationale:

According to ODG Guidelines the role of Deprizine, a gastrointestinal (GI) protective agent would not be indicated as this employee does not meet GI risk factors to support use with medications at present. There is no indication of an age greater than 65 years old, history of peptic ulcer, GI bleeding or perforation, concordant use of aspirin with corticosteroids, anti-coagulants or high-dose multiple nonsteroidal usage. **The request for Dicapanol 5mg/ml Oral Suspension 150 ml at bedtime, QTY: 1.00 is not medically necessary and appropriate.**

/sm

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]
[REDACTED]
[REDACTED]

CM13-0005621