

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	10/21/2011
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006219

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Gabaketo-L 6%/20%/6.15% ultracream** is not medically necessary and appropriate.

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/27/2013. 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 **Gabaketo-L 6%/20%/6.15% ultracream** 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 Family Practice, 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 patient is a 39-year-old female who reported an injury on 10/21/2011. The mechanism of injury was not provided. The physical examination indicated that the patient had hand and wrist pain that fluctuated with intensity and was noted to have had cortisone injections as well as acupuncture. Physical examination revealed positive Tinel's, Phalen's with thenar weakness, and a positive Finkelstein's. The patient's diagnosis was stated to be right wrist de Quervain's tenosynovitis with volar ganglion cyst improved. The treatment was to use Gabaketo-L 6%/20%/6.15% ultracream.

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

**1) Regarding the request for Gabaketo-L 6%/20%/6.15% ultracream :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the MTUS Definitions, (e) “Functional improvement”, MTUS, Compounded Medications, which are part of MTUS and the Official Disability Guidelines, (ODG), Pain Chapter, which is not part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Topical Analgesics, page 111, Lidocaine, page 112, Ketoprofen, page 112 and Gabapentin, page 113, which are part of MTUS.

Rationale for the Decision:

The California MTUS indicates that a compounded product that contains at least one drug or drug class which is not recommended is not recommended. Gabapentin, Ketoprofen, and Lidocaine in any form other than a Lidocaine patch is not medically approved as a topical analgesic. The clinical documentation provided for review indicates that the employee had constant pain in the left hand and pain in the wrist that fluctuated in intensity, but the documentation failed to provide evidence of exceptional factors to warrant non-adherence to guideline recommendations. **The request for Gabaketo-L 6%/20%/6.15% ultracream 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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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.