

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/2/2013
Date of Injury:	4/3/2007
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007068

- 1) MAXIMUS Federal Services, Inc. has determined the request for **FLUR/CYCLO/CAPS/LID 10% 2% 0.0125% 1% refill: 3 #120 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **KETO/LIDOC/CAP/TRAM 15% 1% 0.0125% refill:3 #120 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/4/2013. 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 **FLUR/CYCLO/CAPS/LID 10% 2% 0.0125% 1% refill: 3 #120 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **KETO/LIDOC/CAP/TRAM 15% 1% 0.0125% refill:3 #120 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.

Expert Reviewer Case Summary:

The patient is a 53-year-old male who reported an injury on 4/3/2007 to his right shoulder when he was unloading a 300 pound television set from his truck with another person and the other person lost his grip on the television set causing the patient to reach over the T.V. to keep it from falling and he developed sharp pain in his neck, right shoulder and back. The patient is noted to have been treated conservatively with physical therapy, medications and injections to the right shoulder. On 4/11/2013, the patient was seen for an orthopedic consult by Dr. [REDACTED] who reported the patient complained of pain in his right shoulder that radiates from the neck down the right arm associated with numbness and tingling sensation with increased pain with lifting and carrying more than 10 pounds. Pain was aggravated by overreaching, moving his arm backwards, lifting his right upper extremity above shoulder level. On physical exam, the patient had mild tenderness to the acromioclavicular joint with cross body abduction and almost every motion caused pain posteriorly in the shoulder. The patient was able to get about 150 degrees of forward flexion and with active assistance he could go to 175 degrees. The patient had positive Neer's and Hawkin's sign. External rotation at 50 degrees and internal rotation at 50 degrees. His strength in external rotation of the supraspinatus was 4/5. He had no obvious proximal biceps injury and when attempting to load the biceps anchor causes posterior pain. Foraminal compression tests were negative but did cause neck pain. He is reported to have some thenar weakness as well as intrinsic weakness. An electrodiagnostic study showed carpal tunnel syndrome and throughout the exam the patient was noted to shake his hand because of numbness. X-rays of the right shoulder noted some mild degenerative changes of the acromioclavicular joint, no significant glenohumeral arthrosis, but they did show some

mild wear posteriorly of the glenoid. The acromion was nearly flat. MRI of the shoulder was reported to show some partial tearing with supraspinatus with some bursitis. A request was submitted for authorization of flur/cyclo/caps/lid 10% 2% 0.0125% 1% with 3 refills and keto/lidoc/cap/tram 15% 1% 0.0125% with 3 refills.

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 FLUR/CYCLO/CAPS/LID 10% 2% 0.0125% 1% refill: 3 #120:

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 Chronic Pain Medical Treatment Guidelines, (2009), Topical Analgesics – Muscle Relaxants, pages 111-112, which is part of the MTUS.

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

Rationale for the Decision:

The Chronic Pain guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The guidelines indicate there is little or no research to support the use of many of the agents in the requested medication. The guidelines state that cyclobenzaprine used as a topical muscle relaxant is not recommended, and any form of lidocaine other than Lidoderm patches is not recommended. As the requested compounded medication contains cyclobenzaprine and lidocaine, the requested compounded medication does not meet guideline recommendations. **The request for FLUR/CYCLO/CAPS/LID 10% 2% 0.0125% 1% refill: 3 #120 is not medically necessary and appropriate.**

2) Regarding the request for KETO/LIDOC/CAP/TRAM 15% 1% 0.0125% refill:3 #120:

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 Chronic Pain Medical Treatment Guidelines, (2009), Topical Analgesics – Muscle Relaxants, pages 111-112, which is part of the MTUS.

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

Rationale for the Decision:

The Chronic Pain guidelines do not recognize the use of ketoprofen as a topical non-steroidal analgesic as it is not FDA approved for topical application and it has a high incidence of causing photocontact dermatitis. Further, the guidelines do not recommend the use of lidocaine as a topical application except for in the use of Lidoderm patches. As such, the requested keto/lidoc/cap/tram compounded preparation does not meet guideline recommendations. **The request for KETO/LIDOC/CAP/TRAM 15% 1% 0.0125% refill: 3 #120 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, 18th Floor
Oakland, CA 94612

/sab

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.