

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/14/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/15/2013
Date of Injury:	11/29/2010
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0007505

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Gabapentin 10%/ Cyclobenzaprine 10%/ Capsaicin 0.0375% topical cream is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Flurbiprofen 20% topical cream is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Ketoprofen 20%/ Ketamine 10% topical cream 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 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. 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 **Gabapentin 10%/ Cyclobenzaprine 10%/ Capsaicin 0.0375% topical cream** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Flurbiprofen 20% topical cream** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Ketoprofen 20%/ Ketamine 10% topical cream** 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 who reported an injury on 11/29/2010. The mechanism of injury is not specifically stated. An unofficial MRI report of the left shoulder was submitted on 11/13/2012 by Dr. [REDACTED], which indicated lateral downsloping to the acromion, type II acromion, hypertrophy of the acromioclavicular joint, mild amount of fluid around the long head of the biceps tendon, tendonitis at the site of insertion of the supraspinatus tendon, and fluid around the long head of the biceps tendon in the bicipital groove. An unofficial MRI report of the lumbar spine was then submitted on the same date of 11/13/2012 by Dr. [REDACTED], which indicated normal alignment to the lumbar spine with normal curvature, T10-T11 loss of intervertebral disc height with a 2 mm central disc protrusion, L2-3 disc desiccation, L4-5 mild loss of posterior disc height, and L5-S1 disc desiccation with a mild loss of intervertebral disc height. The patient was seen by Dr. [REDACTED] on 01/10/2013 for a followup evaluation. It is noted that in the last visit a subacromial injection was administered. The patient reported relief for 3 weeks following the injection. Physical examination revealed tenderness at the coracoacromial space and subacromial space, positive isolation and impingement testing, weakness of external rotation and abduction, tenderness at the biceps, and intact sensory and motor examination. Physical examination of the lower back revealed diffuse tenderness at L5-S1, positive sciatic notch tenderness, positive straight leg raising test, 2+ reflexes, and bowstring signs positive bilaterally.

Diagnoses included protrusion lumbosacral spine at L2-3 and L5-S1 with radiculitis and radiculopathy, and impingement syndrome of the left shoulder with failed injection. Treatment plan included an arthroscopy of the left shoulder followed by 2 to 3 months of postoperative physical therapy. A physical therapy report was submitted on 01/17/2013 detailing the patient's visits from 12/20/2012 to 01/17/2013. Overall documentation revealed continued reports of pain, difficulty sleeping, and stiffness. The patient was then seen by Dr. [REDACTED] 02/06/2013. The patient presented to the office for evaluation of cervical clearance at that time. Physical examination revealed reduced range of motion with associated pain at the spine, ribs, and pelvic areas, with normal range of motion and normal alignment otherwise. It was determined that the patient was medically stable to proceed with surgery at that time. An operative report was then submitted by Dr. [REDACTED] on 02/12/2013, which indicated that the patient underwent high volume lumbar epidural steroid injection at L5-S1, lumbar epidurogram and neurogram with interpretation of fluoroscopic films, under fluoroscopic guidance. The patient again followed up with Dr. [REDACTED] on 02/14/2013. The patient states minimal improvement following epidural steroid injection. He continues to complain of pain with limited range of motion and weakness of the left shoulder. Current medications include Anaprox, Zanaflex, Lortab, and topical creams. Objective findings revealed tenderness in the coracoacromial ligaments and subacromial space with positive isolation testing. A review of the left shoulder MRI revealed downsloping of the acromion, type II acromion, hypertrophy of the acromioclavicular joint, and a prominent coracoacromial ligament with impingement syndrome. Treatment plan included authorization for a left shoulder arthroscopy and continuation of current medications. A review of medical records was submitted by Dr. [REDACTED] on 02/22/2013. It was noted that a procedure was performed on 02/22/2013 to include left shoulder diagnostic arthroscopy of glenohumeral joint, left shoulder resection of subacromial spur, left shoulder resection of coracoacromial ligament, and left shoulder synovectomy. The above mentioned surgical procedure was noted on 02/22/2013 by Dr. [REDACTED]. The patient was seen by Dr. [REDACTED] on 03/01/2013 and 03/11/2013. The patient continued to rate 6/10 pain on the left shoulder following the arthroscopic surgery. Objective findings revealed limited range of motion, weakness, 4/5 strength, and intact sensation of the upper extremities. Treatment plan included continuation of physical therapy and current medications. An operative report was then submitted on 06/18/2013 by Dr. [REDACTED], indicating that the patient underwent an additional high volume lumbar epidural steroid injection at L5-S1 bilaterally with epidurogram and neurogram under fluoroscopic guidance. A medical review report was then submitted on 07/15/2013. Specific treatments requested included 1 prescription for gabapentin 10%/cyclobenzaprine 10%/capsaicin 0.0375% topical cream, 1 prescription for flurbiprofen 20% topical cream, and 1 prescription for ketoprofen 20%/ketamine 10% topical cream administered between 05/31/2013 and 08/29/2013. The above mentioned requests were all non-certified at that time.

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 Gabapentin 10%/ Cyclobenzaprine 10%/ Capsaicin 0.0375% topical cream:

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, Topical Analgesics, which is part of the MTUS.

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

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines recommend topical analgesics as an option for treatment, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug that is not recommended is not recommended as a whole. Gabapentin is not recommended for topical use. There is no evidence for use of any other antiepilepsy drugs as a topical product as well. Capsaicin is only recommended as an option in patient who have not responded or are intolerant to other treatments. Indications include osteoarthritis, fibromyalgia, and chronic nonspecific back pain. As per the clinical notes submitted, there is no indication that this employee has not responded to other methods of treatment. There is also no indication that this employee suffers from a diagnosis of osteoarthritis, or fibromyalgia corroborated by imaging studies or objective physical findings. California Guidelines also state that there is no evidence for use of any other muscle relaxants as a topical product. The guideline criteria have not been met. **The request for Gabapentin 10%/ Cyclobenzaprine 10%/ Capsaicin 0.0375% topical cream is not medically necessary and appropriate.**

2) Regarding the request for Flurbiprofen 20% topical cream:

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, Topical Analgesics, which is part of the MTUS.

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

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines recommend topical analgesics as an option for treatment of neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical note submitted, there is no indication that this employee has failed a trial of antidepressants and anticonvulsants prior to the request for a topical analgesic. California Guidelines also state that NSAIDs are recommended for short-term use of 4 to 12 weeks. The only FDA approved agent for topical use is diclofenac or Voltaren gel.

There is no documentation submitted that provides evidence of diagnosis of osteoarthritis or tendonitis, corroborated by clinical imaging or physical findings. Duration for use of a topical NSAID includes 4 to 12 weeks. There is no evidence provided of significant functional improvement following the use of this medication. Additionally noted, the only FDA approved NSAID agent for topical analgesia includes Voltaren gel or diclofenac. The guideline criteria have not been met. **The request for Flurbiprofen 20% topical cream is not medically necessary and appropriate.**

3) Regarding the request for Ketoprofen 20%/ Ketamine 10% topical cream:

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, Topical Analgesics, which is part of the MTUS.

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

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines state that topical analgesics are recommended as an option for treatment of neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. NSAIDs are approved for treatment of osteoarthritis and tendonitis in particular that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for a short-term use of 4 to 12 weeks. The only FDA approved agent includes Voltaren gel 1% (diclofenac). Ketamine is currently under study, and only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. As per the clinical notes submitted, there is no evidence of a diagnosis of osteoarthritis, tendonitis, CRPS 1, or postherpetic neuralgia, corroborated by objective findings or clinical imaging studies. Additionally noted, there is no evidence that all primary and secondary treatments have been exhausted for this employee. The guideline criteria have not been met. **The request for Ketoprofen 20%/ Ketamine 10% topical cream 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

/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.