

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/5/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/13/2013

7/14/2011

8/6/2013

CM13-0007957

- 1) MAXIMUS Federal Services, Inc. has determined the request for compound Ketoprofen 20% in PLO gel 120gm **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for compound Cyclophene 5% in PLO gel 120gm **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/13/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/9/2013. 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 compound Ketoprofen 20% in PLO gel 120gm **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for compound Cyclophene 5% in PLO gel 120gm **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 41-year-old male who reported an injury to his low back on 07/14/2011. The clinical note dated 06/13/2013 noted the patient underwent a lumbar discectomy and fusion in 02/2013 and the patient was gradually improving. He reported he felt numb all the way in the S1 dermatomal distribution, although the pain is not as bad as it was before. He reported he had back pain which gave him some trouble with motion, but otherwise he was getting better slower than expected. On neurological exam, the patient had no motor deficits and no apparently sensory deficits; 2+ reflexes at the knees and 1+ reflexes at the ankles. The patient is noted to be status post PLIF at L5-S1 on 02/14/2013. The patient was recommended additional physical therapy on that date. The clinical note dated 06/26/2013 signed by Dr. [REDACTED] reported the patient complained of constant pain in his right lateral back rated 8/10. He reported his pain was worsening. He had stiffness on the spine and radicular symptoms to the right lower extremity. On physical examination, the patient is noted to have negative Minor's sign, heel walk and toe walk, and Patrick-FABER on both sides; Valsalva, Kemp's test, Yeoman's test, and iliac compression caused pain on both sides. Reflexes at the knees were normal bilaterally and at the hamstrings were noted bilaterally. The patient had no loss of sensibility, abnormal sensation, or pain in the groin and hip on the right. The patient is noted to have moderate paraspinal tenderness bilaterally, right greater than left on palpation from T12-S1. Lumbar range of motion was noted to be extremely limited with severe pain at range of motion. On 07/31/2013, the patient is noted to continue to complain of constant pain in his right lower back radiating to his right lower extremity which he continued to rate 8/10. He reported he needed to wear a lumbar brace when sitting due to pain. He was reported to have difficulty falling asleep due to

pain, waking at night with pain, symptoms of anxiety and depression, and weight gain since his date of injury. He reported numbness and tingling radiating to his right upper extremity. He reports his pain reduced with rest and he had been receiving chiropractic treatments for the last 2 weeks which he reported to be helpful. A request was submitted for compounded ketoprofen 20% gel and compounded cyclobenzaprine 5% gel.

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 compound Ketoprofen 20% in PLO gel 120gm:

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, Ketoprofen, which is part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, Pages 111-112, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended and recommends the use of topical NSAIDs only for treatment of osteoarthritis and states there is little evidence utilizing NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. In addition, ketoprofen is not FDA approved for treatment as a topical application as there is extremely high incident of photocontact dermatitis. As the employee is noted to complain of low back pain, there is no indication for the use of topical non-steroidal anti-inflammatories as they are not recommended for osteoarthritis of the spine. In addition, ketoprofen is not FDA approved for topical application. The guideline criteria have not been met. **The request for compound Ketoprofen 20% in PLO gel 120gm is not medically necessary and appropriate.**

**2) Regarding the request for compound Cyclophene 5% in PLO gel 120gm:
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 California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Topical Analgesics, Pages 111-113, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines state there is little to no research to support the use of many of these agents and any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. They also state there is no evidence for use of muscle relaxants as a topical product. The requested compound topical gel containing cyclobenzaprine does not meet guideline recommendations. **The request for compound Cyclophene 5% in PLO gel 120gm 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.