

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 11/8/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/1/2013
Date of Injury:	9/30/2004
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0008253

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Ketoprofen cream is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #180 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Pamelor 25mg #60 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Naproxen 550mg #120 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 8/1/2013. 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 **Ketoprofen cream is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #180 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Pamelor 25mg #60 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Naproxen 550mg #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 65-year-old male who reported an injury on 09/30/2004. He is reported to complain of ongoing low back pain. Electrodiagnostic performed on 08/28/2012 of the bilateral lower extremities noted electrodiagnostic evidence of chronic left L5 radiculopathy and bilaterally symmetrically prolonged H-wave suggest bilateral S1 nerve root involvement. There was no evidence of focal nerve entrapment or generalized peripheral neuropathy affecting the lower limbs. MRI of the lumbar spine performed on 11/16/2012 noted multilevel severe degenerative disc disease and facet arthropathy with extensive postoperative changes and retrolisthesis of L1 on L2 through L5. At T12-L1, a large central disc extrusion with central canal stenosis including central canal stenosis was noted to be mild to moderate at L2-3, moderate at L3-4 and L4-5, and mild to moderate at L5-S1 with neural foraminal narrowing at L1-2; bilaterally, L2-3 moderate to severe on the right and severe on the left; L3-4, moderate to severe on the left and severe on the right; L3-4, severe bilaterally; L5-S1, mild on the right and moderate on the left. The patient is reported to complain of ongoing low back and neck pain. The clinical note dated 06/12/2013 reported the patient complained of pain rated 6/10 to 8/10 and numbness and tingling extending to the left foot. He was reported to have limitations with his activities due to his pain complaints. He reported his medication was helping with his pain levels and allowing for an increased level of function with no side effects. On physical exam, the patient was noted to have an antalgic gait due to

increased knee complaints. He had well-healed scars in the lumbar spine with tenderness to palpation of the lumbar paraspinals at approximately L4-S1. Range of motion of the lumbar spine was decreased and the patient is noted to have decreased sensation at left L3, L4, L5, and S1 dermatomes. The left tibialis anterior (TA), extensor hallucis longus (EHL), and inversion was 5-, plantar flexion was 4-, and eversion was 4+. Reflexes were intact in the lower extremities. On 07/03/2013, the patient was noted to complain of ongoing neck and back pain. He said his back pain was the worst; he rated it 7/10 to 9/10. He also had neck pain rated 4/10. He reported continued numbness and tingling extending to the left foot. He had some limitations in his activities and reported his medications were outdated from his pain level for increased level of function. The patient was noted to have a normal gait. Range of motion of the cervical spine and lumbar spine were limited in all planes. His gait was largely antalgic due to left knee complaints and he had tenderness to palpation over the bilateral lumbar paraspinal region at L4-5, diminished sensation in the L3, L5, and S1 dermatomes, decreased strength in the left anterior tibialis and EHL in inversion, plantar flexion, and eversion.

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 Ketoprofen 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, which is part of the MTUS.

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

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines indicate that Ketoprofen has not been approved for topical application by the FDA as it has an extremely incidence of photocontact dermatitis and recommends the use of non-steroidal anti-inflammatories for treatment of osteoarthritis and tendinitis, especially in the knee, elbow, or other joints that are amiable to topical treatment and not for treatment of osteoarthritis of the spine, hip, or shoulder as there is little evidence for the utilization of NSAIDs. The requested ketoprofen cream does not meet guideline recommendations. **The request for Ketoprofen cream is not medically necessary and appropriate.**

2) Regarding the request for Norco 10/325mg #180:

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, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, Criteria for use, Page 78, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that there should be ongoing review of documentation of the patient's pain relief, functional status, appropriate medication use, or side effects. The pain assessment should include current pain, least reported pain over the period since the last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief afterwards, and how long the pain relief lasts and satisfactory response to treatment may be indicated by decreased pain, increased level of function, or improved quality of life. The medical records provided for review do not indicate the employee receives decreased pain with the use of this medication or that the employee has increased level of function with utilization of the medication or improved quality of life. **The request for Norco 10/325mg # 180 is not medically necessary and appropriate.**

3) Regarding the request for Pamelor 25mg #60:

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

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antidepressants for Chronic Pain, pages 13-15, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines recommend the use of Pamelor, which is a tricyclic antidepressant as a first-line agent unless they are ineffective, poorly tolerated or contraindicated. An assessment of treatment efficacy should include not only pain outcomes, but evaluation of function, change in the use of other analgesic medications, sleep quality and duration, and psychological assessment. The medical records provided for review do not indicate that the employee has decreased pain or increased level of function with the use of this medication, which does not meet guideline recommendations. **The request for Pamelor 25mg #60 is not medically necessary and appropriate.**

4) Regarding the request for Naproxen 550mg #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, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), pages 67-68, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines recommend the use of non-steroidal anti-inflammatories as a second-line treatment after acetaminophen for acute exacerbations of chronic low back pain and recommended as an option for short-term symptomatic relief for chronic low back pain. The medical records provided for review indicate that the employee has been taking this medication for treatment of low back pain on a long-term ongoing basis, the requested medication does not meet guideline recommendations. **The request for naproxen 550mg #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

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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.