

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/30/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/18/2013
Date of Injury: 5/28/2010
IMR Application Received: 8/14/2013
MAXIMUS Case Number: CM13-0012852

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 05/28/2010. The patient's diagnoses include lumbar vertebral disc syndrome, lumbar radiculitis, post surgical status, and internal derangement of the knee. Multiple recent Peer-2 reports are handwritten and only partially legible. A prior treating physician's report from 01/18/2013 outlines the patient's history in detail including impressions of lumbar sprain, lumbar radiculitis, internal derangement of the left knee, status post left knee arthroscopy, and left plantar fasciitis. Initial physician review indicated that the medical records do not support the medical necessary of the requested treatment.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Omeprazole 20mg #100 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pages 68-69, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section on Anti-inflammatory Medications and Gastrointestinal Symptoms, page 68, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines, section on anti-inflammatory medications and gastrointestinal symptoms states the clinician should "determine if the patient has a risk for gastrointestinal events: Age greater than 65 years, history of peptic ulcer or GI bleeding, concurrent use of aspirin or corticosteroids, high dose/multiple NSAIDs." The medical records

at this time do not provide such information regarding indication for omeprazole as requested. This treatment is not medically necessary.

2. Gabaketolido cream 240gm #1 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Section on Topical Analgesics, page 111-113, which is part of the MTUS.

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

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines, section on topical analgesics, page 111, states, "Any compounded product that contains at least one drug that is not recommended is not recommended..." The guidelines indicate that Gabapentin is not recommended and Ketoprofen is not currently FDA approved for a topical application because it has extremely high incidents of photo contact dermatitis. At least two components of this compounded medication are specifically not recommended by the guidelines. Therefore, overall this request is not medically necessary.

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.

[REDACTED]
[REDACTED]
[REDACTED]

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