

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/31/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/31/2013
Date of Injury: 8/31/1998
IMR Application Received: 8/20/2013
MAXIMUS Case Number: CM13-0013967

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 Anesthesiology, has a subspecialty in Pain Management 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:

This patient is a 71 year old injured female with a date of injury of 8/31/98. She underwent UR review on 7/29/13. The most recent provider note reviewed by UR physician were from 12/20/2012. The injured worker has suffered from lower back pain, and been diagnosed with discopathy and lumbar radiculopathy, and treatment has been notable for plans for epidural steroid injections and topical as well as systemic medications (naproxen, tizanidine). She has pursued a Home Exercise Program as part of her treatment. Physical exam has noted reduced sensation in a lower extremity dermatome. Stenosis and right sided L5/S1 disc herniation was noted on MRI of the lumbar spine.

IMR DECISION(S) AND RATIONALE(S)

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

1. Ketoprofen (NAP) cream is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Guidelines, which are a part of the MTUS.

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

The Physician Reviewer's decision rationale:

The MTUS guidelines indicate that topical medications are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of

systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, α -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The MTUS also notes that the indications of topical analgesics are osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment, and only recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. According to the medical records provided for review, the employee does not have a condition for which the ingredients in the requested cream are recommended. **The request for Ketoprofen (NAP) cream is not medically necessary and appropriate.**

2. CAPS (NAP) cream-5 + TGC is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Guidelines, which are a part of the MTUS.

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

The Physician Reviewer's decision rationale:

CAPS (NAP) cream contains capsaicin, camphor, and menthol. Capsaicin may have an indication for chronic pain in this context. MTUS guidelines indicate that although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. However, the preponderance of evidence indicates that overall this medication is not medically necessary. The MTUS guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The CA MTUS guidelines provide no evidence-based recommendations regarding the topical application of menthol. Since menthol is not medically indicated, then the overall product is not indicated per MTUS as outlined above. **The request for CAPS (NAP) cream is not medically necessary and appropriate.**

/dso

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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