
Notice of Independent Medical Review Determination

Dated: 10/23/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/4/2013
Date of Injury:	9/27/2012
IMR Application Received:	7/24/2013
MAXIMUS Case Number:	CM13-0003026

- 1) MAXIMUS Federal Services, Inc. has determined the request for 8 physical therapy sessions **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a prescription Zanaflex 2mg #90 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for compound medication: Flurbiprofen 20% gel 120gm **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for compound medication: Ketoprofen 20%/ketamine 10% gel 120gm **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for compound medication: Gabapentin 10%/Cyclobenzaprine 10% + Capsaicin 0.0375% 120 gm **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for 6 shockwave therapy sessions **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for x-rays of the lumbar spine **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/4/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 8 physical therapy sessions **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a prescription Zanaflex 2mg #90 **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for compound medication: Flurbiprofen 20% gel 120gm **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for compound medication: Ketoprofen 20%/ketamine 10% gel 120gm **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for compound medication: Gabapentin 10%/Cyclobenzaprine 10% + Capsaicin 0.0375% 120 gm **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for 6 shockwave therapy sessions **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for x-rays of the lumbar spine **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 & 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 4, 2013:

“The patient is a forty-five-year-old woman who was injured on 9/27/12. Dr. [REDACTED] MD saw the patient on 6/17/13 for orthopedic consultation of her low back pain. She previously attended 6 PT sessions without improvement. She was released to full duty and developed depression, anxiety, stress, and difficulty sleeping due to high levels of

pain and discomfort. She reported numbness and tingling in her right leg. She had difficulty with ADLs. Exam noted she is 60 inches and 168 pounds (BMI33). There was lumbar tenderness, TPI "at 2+", limited Rom, decreased bilateral EHL and bilateral gastrocs strength 2+ knee DTRs, 1+ ankle DTRs."

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 for Independent Medical Review (received 7/24/2013)
- Utilization Review Determination from [REDACTED] (dated 7/4/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

1) Regarding the request for 8 physical therapy sessions:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Low Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition, (2004), Chapter 12, page 309), which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Chronic Pain Medical Treatment Guidelines, pages 98-99, which are part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Guidelines section used by the Claims Administrator.

Rationale for the Decision:

The employee sustained a work-related injury on 9/27/2012 to the lower back. The employee has developed depression, anxiety, stress, and difficulty sleeping. Treatments have included physical therapy and medication management. The request is for 8 physical therapy sessions.

The MTUS Chronic Pain guidelines recommend 8 to 10 visits over 4 to 8 weeks for treatment of neuralgia, neuritis, and radiculitis; as well as myalgia and myositis. The medical records submitted for review indicates that the employee has been treated with an initial course of 6 sessions of physical therapy with no significant improvement. Furthermore, the requested 8 physical therapy sessions combined with prior 6 sessions exceeds the recommendation of the guidelines. The request for 8 physical therapy sessions **is not medically necessary and appropriate.**

2) Regarding the request for a prescription Zanaflex 2mg #90:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based guidelines. The provider did not dispute the guidelines used by the Claims Administrator. The

Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Page 66, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 9/27/2012 to the lower back. The employee has developed depression, anxiety, stress, and difficulty sleeping. Treatments have included physical therapy and medication management. The request is for prescription Zanaflex 2mg #90.

The MTUS Chronic Pain Guidelines indicate that tizanidine (Zanaflex) is a centrally acting alpha2 adrenergic agonist that is FDA approved for the management of spasticity with unlabeled use for low back pain. The documentation submitted for review indicates the employee has lumbar paraspinal musculature spasms. The request for prescription Zanaflex 2mg #90 **is medically necessary and appropriate.**

3) Regarding the request for compound medication: Flurbiprofen 20% gel 120gm:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Topical Analgesics section, which is a medical treatment guideline that is not a part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Pages 111-112, which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 9/27/2012 to the lower back. The employee has developed depression, anxiety, stress, and difficulty sleeping. Treatments have included physical therapy and medication management. The request is for compound medication: Flurbiprofen 20% gel 120gm.

The MTUS Chronic Pain Guidelines indicate that Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control including NSAIDs. Non-steroidal antiinflammatory agents have largely been in question given that efficacy in clinical trials for this treatment modality has been inconsistent with most studies being small and of short duration. The documentation submitted for review indicates that the patient was prescribed these medications for the purpose of minimizing possible GI and neurovascular complications and to avoid complications associated with the use of narcotic medications, as well as upper GI bleeding from the use of NSAID medications. There was no clear clinical rationale stated for prescribing topical NSAIDs in conjunction with Anaprox 550 mg for oral intake; and given their similar mechanisms of action, efficacy of one medication versus the other would not be easily determined. Furthermore, there

was no indication in the documentation of current GI symptoms of the patient to indicate the necessity for the application of topical therapy. The request for compound medication: Flurbiprofen 20% gel 120gm **is not medically necessary and appropriate.**

4) Regarding the request for compound medication: Ketoprofen 20%/ketamine 10% gel 120gm:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Topical Analgesics section, which is a medical treatment guideline that is not a part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Pages 111-112, which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 9/27/2012 to the lower back. The employee has developed depression, anxiety, stress, and difficulty sleeping. Treatments have included physical therapy and medication management. The request is for compound medication: Ketoprofen 20% ketamine 10% gel 120 gm.

The MTUS Chronic Pain Guidelines indicate that topical analgesics are largely experimental and used with few randomized control trials to determine their efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, any compounded product that contains at least 1 drug or drug class that is not recommended, is not recommended. The current prescription for ketoprofen 20%/ketamine 10% gel is not supported. Ketamine is currently under study and is only recommended for treatment of neuropathic pain and refractory cases in which all primary and secondary treatment has been exhausted. While ketoprofen is not currently FDA approved for topical application, as it has an extremely high incidence of photocontact dermatitis. There was no clear clinical rationale stated for prescribing topical NSAIDs in conjunction with Anaprox 550 mg for oral intake; and given their similar mechanisms of action, efficacy of one medication versus the other would not be easily determined. The request for compound medication: Ketoprofen 20% ketamine 10% gel 120 gm **is not medically necessary and appropriate.**

5) Regarding the request for compound medication: Gabapentin 10% Cyclobenzaprine 10% + Capsaicin 0.0375% 120gm:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Topical Analgesics section, which is a medical treatment guideline that is not a part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The

Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Pages 111-112, which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on September 27, 2012 to the lower back. Treatments have included physical therapy, and medication management. The request is for compound medication: Gabapentin 10% Cyclobenzaprine 10% + Capsaicin 0.0375% 120gm.

The MTUS Chronic Pain Guidelines indicate that gabapentin is not recommended. Furthermore, capsaicin is not recommended in a formulation of 0.0375%, as there have been no studies with this formulation or current indication that this increase over a 0.025% formulation would provide any further efficacy. The request for Gabapentin 10% Cyclobenzaprine 10% + Capsaicin 0.0375% 120gm **is not medically necessary and appropriate.**

6) Regarding the request for 6 Shockwave therapy sessions:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pages 100-101, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined that the MTUS does not address the issue in dispute. The Expert Reviewer based his/her decision on the ODG, Low Back Chapter, Shockwave Therapy section, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 9/27/2012 to the lower back. The employee has developed depression, anxiety, stress, and difficulty sleeping. Treatments have included physical therapy and medication management. The request is for 6 Shockwave therapy sessions.

The ODG indicates that shockwave therapy is not recommended for the lower back due to lack of evidence of its efficacy. Documentation submitted for review further indicates that the employee underwent 1 session on 08/09/2013 of extracorporeal shockwave therapy. However, there is a lack of documentation indicating the employee's response to the treatment. The request for 6 Shockwave therapy sessions **is not medically necessary and appropriate.**

7) Regarding the request for X-Rays of the lumbar spine:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS), but did not list a specific section. The provider did not dispute the guidelines used by the Claims

Administrator. The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, 2004, Low Back Complaints, pages 303-305, which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 9/27/2012 to the lower back. The employee has developed depression, anxiety, stress, and difficulty sleeping. Treatments have included physical therapy and medication management. The request is for x-rays of the lumbar spine.

The ACOEM guidelines indicate that special studies such as lumbar spine x-rays should not be recommended in individuals with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. The documentation submitted for review indicates the employee to have ongoing complaints of low back pain resulting from repetitive lifting. Given that the employee was initially evaluated on 10/01/2012 with radiographic studies, the additional studies obtained on 06/17/2013 would have been unnecessary, as it is unclear how this would have affected or changed the course of the employee's treatment plan. The request for x-rays of the lumbar spine **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

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.