

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/3/2013
Date of Injury: 10/12/2011
IMR Application Received: 7/29/2013
MAXIMUS Case Number: CM13-0004713

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]
[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 Internal Medicine and Cardiology, has a subspecialty in Fellowship Trained in Cardiovascular Disease and is licensed to practice in Texas. 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 case involves a 58-year-old female that reported a work-related injury on 10/12/2011. The patient was diagnosed with two fractures in the lumbar spine at that time. The clinical note on 04/09/2013 indicates that the patient reported a pain level of 8/10 to 9/10. The patient's main complaint was to lumbar and the left knee. The patient had left knee open incision and drainage done on 06/2012. The patient was seen on 05/21/2013 with reported left knee and low back pain. The patient reported still having continued stiffness, achiness, and pain in regard to her left knee and difficulty with prolonged weight-bearing activities. An MRI lumbar spine done 04/26/2013 showed evidence of degenerative disc disease. An MRI of the left knee on 04/26/2013 revealed postsurgical changes with moderate scarring and stable patellofemoral chondromalacia. The patient was recommended for a Synvisc injection due to her stiffness, achiness, and pain. The patient was also recommended for physical therapy and a referred to pain management specialist Dr. [REDACTED] for a possible epidural steroid injection.

IMR DECISION(S) AND RATIONALE(S)

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

1. Flurbiprofen 15%/Cyclobenzaprine 10%/Ultraderm #240 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS. The Claims Administrator also cited that ACOEM Guidelines and the ODG-TWC, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical analgesics, pages 41-42, and 111-112, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that topical analgesics are recommended as an option and for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. The topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many of the agents are compounded as monotherapy or in combination for pain control. There is little or no research to support the use of many of these agents. If a compounded product contains at least one drug (or drug class) that is not recommended, then the compound is not recommended. The medication, flurbiprofen, is a NSAID that is recommended for short-term use only. The other compound cyclobenzaprine is a skeletal muscle relaxant and central nervous system depressant, which is not recommended to be used with other agents. The medical records provided for review did not support the usage for the analgesic compound. **The request for Flurbiprofen 15%/Cyclobenzaprine 10%/Ultraderm #240 is not medically necessary and appropriate.**

2. Tramadol 8%/Gabapentin powder 10%/Menthol 2%/Capsaicin 0.5%/Ultraderm #240 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS. The Claims Administrator also cited that ACOEM Guidelines and the ODG-TWC, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical analgesics, pages 111-112, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that topical analgesics are recommended as an option and for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. The topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are compounded as monotherapy or in combination for pain control. Any compounded product that contains at least 1 drug or drug class that is not recommended, the topical analgesic compound is not recommended due to required knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The gabapentin is not recommended. The medical records provided for review did not support the usage for the analgesic compound. **The request for Tramadol 8%/Gabapentin powder 10%/Menthol 2%/Capsaicin 0.5%/Ultraderm #240 is not medically necessary and appropriate.**

/sh

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]

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