

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
P.O. Box 138009  
Sacramento, CA 95813-8009  
(855) 865-8873 Fax: (916) 605-4270



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**Notice of Independent Medical Review Determination**

Dated: 11/6/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/19/2013
Date of Injury:	9/15/2003
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006341

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Ketoprofen 10%/3%/5% compound 30 day supply** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Flubiprofen 20%/10% compound 30 day supply** is not medically necessary and appropriate.

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/26/2013. 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 10%/3%/5% compound 30 day supply is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Flubiprofen 20%/10% compound 30 day supply 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 Anesthesiology 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.

### **Expert Reviewer Case Summary:**

S.P. is a 61 year old female with chronic neck pain, date of injury 9/15/03. Diagnosis of cervical sprain/strain, bilateral carpal tunnel syndrome. Chart reviewed. 11/21/08- MRI noting mild spinal canal stenosis from C3-4 through C5-6 due to disc protrusion. Uncinate and facet arthropathy from C3-3 through C5-6 levels. Previous bilateral carpal tunnel surgery. Status post cervical epidural steroid injection (CESI) initial 2 with help, last without help. Requesting provider's medical report dated 6/4/13: pain in neck with pain into the bilateral shoulders elbows and hands. Numbness, tingling and burning pain PE: decreased range of motion with pain. Spurling's test is positive. Positive axial compression test. Spasms and tenderness +2 hypoesthesia in the upper extremities at C4, C5, C6, C7, C8 and T1 levels with facet joint tenderness bilaterally. Upper extremity muscle strength test is 4/5 bilaterally with pain. Diagnosis: Cervical herniated disc at C4-5, bilateral shoulder impingement with tendinopathy, rotator cuff tear, left greater than right, bilateral elbow lateral epicondylitis, s/p bilateral carpal tunnel release surgery, right hand 3<sup>rd</sup> digit trigger finger, psychophysiological depression related to chronic pain. Plan: refill Anaprox, Norco, zanaflex, remeron, prilosec and, topical creams including cyclobenzaprine and capsaicin for full three months. Paraffin wax unit for home use and electrodes.

### **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 10%/3%/5% compound 30 day supply**

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, Pain-Topical Analgesics, page 112, which is part of the MTUS. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics-Non-neuropathic pain (soft tissue injury and osteoarthritis) and compounded, pages 71-73, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that topical analgesics are noted as being experimental with few randomized controlled trials. The medical records provided for review indicate that the employee appears to have an element of neuropathic pain as well as non-neuropathic pain; however, there is little to no research to support the use of these agents in either case. **The request for Ketoprofen 10%/3%/5% compound 30 day supply is not medically necessary and appropriate.**

**2) Regarding the request for Flubiprofen 20%/10% compound 30 day supply:**

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, Pain-Topical Analgesics, pages 23, 64, which is part of the MTUS. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Topical Analgesics-Non-neuropathic pain (soft tissue injury and osteoarthritis) and compounded, pages 71-73, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that topical analgesics are noted as being experimental with few randomized controlled trials. The medical records provided for review indicate that the employee appears to have an element of neuropathic pain as well as non-neuropathic pain; however, there is little to no research to support the use of these agents in either case. **The request for Flubiprofen 20%/10% compound thirty day supply 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, 18<sup>th</sup> 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.