

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

December 24, 2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/22/2013  
Date of Injury: 1/24/2007  
IMR Application Received: 8/7/2013  
MAXIMUS Case Number: CM13-0008209

[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 Neurology, has a subspecialty in Headache, and is licensed to practice in Maryland. 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

### CLINICAL CASE SUMMARY

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

Clinical data submitted indicates the worker has undergone bi-level anterior cervical decompression and fusion and is being prescribed the triple compounded analgesic agent of ketoprofen, gabapentin and lidocaine. There is no documentation of a local inflammatory and neuropathic pain disorder for which the administration of a topical agent might be required and to be found superior to parenteral use of required medications. There is also no evidence that a single agent over-the-counter counter-irritant agent has been trialed and failed to produce symptomatic relief. The medical necessity for this compounded medication cannot be established at this time. ■

### IMR DECISION(S) AND RATIONALE(S)

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

**1. Medication: Ketoprofen/Gabapentin/Lidocaine HCL (Lipo) 1—6-5% cream with 2 refills refills is not medically necessary and appropriate.**

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

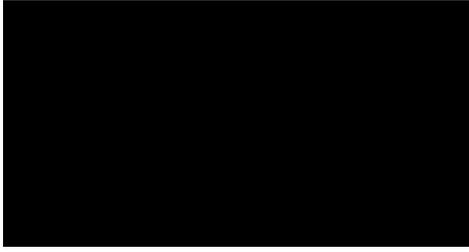
The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists,  $\alpha$ -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists,  $\gamma$  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. Non FDA-approved agents:  
Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. The ordered combo topical contains a non-recommended component, and thus is not recommended. **The request for Medication: Ketoprofen/Gabapentin/Lidocaine HCL (Lipo) 1—6-5% cream with 2 refills refills is not medically necessary and appropriate.**

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.



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