
Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/17/2013
Date of Injury: 11/5/2011
IMR Application Received: 7/26/2013
MAXIMUS Case Number: CM13-0003645

- 1) MAXIMUS Federal Services, Inc. has determined the request for Flurbiprofen 20%/Lido 5%/Menthol 5%/Camp 1% **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Tramadol 15%/Dextro 10%/Cap 0.025% cream **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. 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 Flurbiprofen 20%/Lido 5%/Menthol 5%/Camp 1% **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Tramadol 15%/Dextro 10%/Cap 0.025% cream **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 Preventive Medicine and Occupational Medicine 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:

The applicant, Mr. [REDACTED], is a [REDACTED] employee, who has filed a claim for chronic low back pain, mid back pain, rib pain, and shoulder pain reportedly associated with an industrial injury of November 5, 2011.

Thus far, he has been treated with the following: Analgesic medications; adjuvant medications; topical compounds; unspecified amounts of aquatic therapy; topical applications of heat and cold; transfer of care to and from various providers in various specialties; and apparent return to regular duty work.

A prior impairment study report of October 11, 2012 suggests that the applicant is presently working regular duty. This is echoed by other reports of August 6, 2012, September 4, 2012, January 3, 2013, and March 26, 2013.

The most recent progress report of July 1, 2013 is notable for comments that the applicant reports a flare-up of mid and low back pain as well as rib pain. He exhibits limited range of motion about the same with associated tenderness about the ribs with rotation. Recommendations are made for the applicant to continue his present job, continue home exercises, and use a gym and pool. He is given prescriptions for Motrin, Norco, and topical compounds.

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 7/26/13)
- Utilization Review Determination from [REDACTED] (dated 7/17/13)
- Employee Medical Records from [REDACTED] (received 8/8/13)
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for Flurbiprofen 20%/Lido 5%/Menthol 5%/Camp 1%:
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, Topical Analgesics, pages 111-112, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111 and the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3), Oral Pharmaceuticals, page 47, which are part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental, to be employed in cases of neuropathic pain in which oral antidepressants and/or anticonvulsants have been tried and/or failed. Review of the medical records submitted does not indicate any evidence of neuropathic pain. The employee's pain appears to be muscular/musculoskeletal in nature. The clinical notes do not indicate that there is any evidence of intolerance to and/or failure of oral analgesics. The employee is currently using Motrin and Norco without incident. **The request for Flurbiprofen 20%/Libo 5%/Menthol 5%/Camp 1% is not medically necessary and appropriate.**

**2) Regarding the request for Tramadol 15%/Dextro 10%/Cap 0.025% cream:
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, Opioids, dosing, page 86, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Capsaicin, topical, page 28 and Topical analgesics, page 111, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines indicate that one of the ingredients in the compound capsaicin is considered a last-line agent to be employed in only those individuals who have not responded to and/or are intolerant to other treatments and when one ingredient in a topical compound is not recommended, the entire compound is considered not recommended. Review of the medical records provided indicates that the employee is currently using oral Motrin and Norco without any difficulty, impediment, and/or impairment. **The request for Tramadol 15%/Dextro 10%/Cap 0.025% 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, 18th Floor
Oakland, CA 94612

/db

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.