

---

**Notice of Independent Medical Review Determination**

Dated: 10/21/2013

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/8/2013  
Date of Injury: 6/20/2003  
IMR Application Received: 7/22/2013  
MAXIMUS Case Number: CM13-0002522

- 1) MAXIMUS Federal Services, Inc. has determined the request for Ketoprofen 25%/ Menthol 5%/ Camphor 1%/ Capsaicin 0.025% **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Tramadol 15%/ Dextromethorphan 10%/ Capsaicin 0.025% **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Flurbiprofen 20%/ Lidocaine 5%/ Menthol 5%/ Camphor 1% **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 25%/ Menthol 5%/ Camphor 1%/ Capsaicin 0.025% **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Tramadol 15%/ Dextromethorphan 10%/ Capsaicin 0.025% **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Flurbiprofen 20%/ Lidocaine 5%/ Menthol 5%/ Camphor 1% **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 Family Practice 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 8, 2013:

“This is an injured worker with date of injury 06/20/2003. The patient was evaluated on 10/03/2012. That progress report was handwritten, and partially illegible. The patient had complaints of low back pain, radicular symptoms, and bilateral knee pain. Objective findings included positive SLR. Lumbar range of motion was limited. The patient noted benefit from the medications.

Another progress note was provided date of service 03/13/2013. There were complaints of low back pain with radiculopathy, shoulder pain, and knee pain. Physical examination revealed sensory deficits in the legs. Reflexes were noted to be "Ok." There was decreased lumbar range of motion. There was no limp. Home exercises were demonstrated. There was good medication management.”

### 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 07/22/2013)
- Utilization Review Determination from [REDACTED] (dated 07/05/2013)
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

#### 1) Regarding the request for Ketoprofen 25%/ Menthol 5%/ Camphor 1%/ Capsaicin 0.025% :

##### 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 (2009), pages 111-112, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that the guidelines relevant and appropriate for the employee's clinical circumstances.

##### Rationale for the Decision:

The employee sustained a work-related injury on 6/20/2003, resulting in radicular symptoms, lower back and bilateral knee pain. The medical records provided for review indicate treatments have included home exercises and medication management. The request is for Ketoprofen 25%/ Menthol 5%/ Camphor 1%/ Capsaicin 0.025% :

MTUS/Chronic Pain Medical Treatment guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine their efficacy or safety and they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. The current request for ketoprofen 25%, menthol 5%, camphor 1%, and capsaicin 0.025% is not supported, given that guidelines currently recommend that ketoprofen is not FDA approved due to an extremely high incidence of photocontact dermatitis. The request for Ketoprofen 25%/ Menthol 5%/ Camphor 1%/ Capsaicin 0.025% : **is not medically necessary and appropriate.**

#### 2) Regarding the request for Tramadol 15%/ Dextromethorphan 10%/ Capsaicin 0.025%:

##### 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 (2009), Topical Analgesics, pg. 111, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found

that the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstances.

Rationale for the Decision:

The employee sustained a work-related injury on 6/20/2003, resulting in radicular symptoms, lower back and bilateral knee pain. The medical records provided for review indicate treatments have included home exercises and medication management. The request is for Tramadol 15%/ Dextromethorphan 10%/ Capsaicin 0.025%:

MTUS/Chronic Pain Medical Treatment guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine their efficacy or safety and they are primarily recommended for neuropathic pain when trials of anticonvulsants and antidepressants have failed. The documentation submitted for review is insufficient to indicate that the patient has failed a trial of antidepressants or anticonvulsants prior to proceeding with the use of topical analgesic. The request for Tramadol 15%/ Dextromethorphan 10%/ Capsaicin 0.025%: **is not medically necessary and appropriate.**

**3) Regarding the request for Flurbiprofen 20%/ Lidocaine 5%/ Menthol 5%/ Camphor 1%:**

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 (2009), Topical Analgesics, pgs. 111-112, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstances.

Rationale for the Decision:

The employee sustained a work-related injury on 6/20/2003 resulting in radicular symptoms, lower back and bilateral knee pain. The medical records provided for review indicate treatments have included home exercises and medication management. The request is for Flurbiprofen 20%/ Lidocaine 5%/ Menthol 5%/ Camphor 1%:

MTUS/Chronic Pain Medical Treatment guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine their efficacy or safety and they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Currently, based on the recommendation of the guidelines, the only nonsteroidal anti-inflammatory agent indicated in the topical formulation is Voltaren gel 1%. The request for Flurbiprofen 20%/ Lidocaine 5%/ Menthol 5%/ Camphor 1%: **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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/mbg

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.