

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/19/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/12/2013  
Date of Injury: 3/30/2010  
IMR Application Received: 8/15/2013  
MAXIMUS Case Number: CM13-0011780

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]

## 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Ohio and 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:

The patient is a 54-year-old female who reported an injury on 03/30/2010. The mechanism of injury was not provided for review. The patient was treated conservatively with aquatic therapy and medications. The patient underwent a foraminotomy. The patient had persistent low back pain with radicular symptoms. Physical findings included severe tenderness of the lumbar spine, positive sciatic notch tenderness with painful range of motion, positive right sciatic notch tenderness, decreased motor strength, and decreased sensation of the right lower extremity. The patient was treated with aquatherapy and topical medications to include Terocin, Laxacin, gabapentin/cyclobenzaprine/tramadol cream, Somnicin, and flurbiprofen cream. The patient's diagnosis included lumbosacral radiculopathy. The patient's treatment plan was to continue with topical compounded creams and aquatherapy.

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

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

**1. Terocin Lotion 240gm, date of service 4/2/13 is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The clinical documentation submitted for review did not include a clinical assessment for the requested date of service. The clinical notes indicate that the employee had low back pain radiating into the lower extremities. California Medical Treatment Utilization Schedule stated

“any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended.” The requested Terocin cream does contain topical lidocaine. California Medical Treatment Utilization Schedule states, “no other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain.” Additionally, the requested Terocin does contain capsaicin. This medication is only recommended for topical use for patients who have not responded to or are intolerant of other treatments to include oral medications. The clinical documentation submitted for review does not provide any evidence that the employee is intolerant or has failed to respond to other treatments. Although a topical salicylate is recommended by California Medical Treatment Utilization Schedule to provide relief for chronic pain, the additional components of this formulation are not supported by guideline recommendations. **The request for Terocin Lotion 240gm, date of service 4/2/13 is not medically necessary and appropriate.**

**2. Flurbiprofen (NAP) cream-Lidocaine/Amitriptyline 180gm, date of service 4/2/13 is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer’s decision rationale:

There was no clinical documentation or evaluation submitted for the requested date of service of 04/02/2013. Previous documentation reveals that the employee has low back pain with radicular symptoms. California Medical Treatment Utilization Schedule states “any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended.” The requested compound includes flurbiprofen. Guideline recommendations support the use of this medication for osteoarthritis of knee and elbow joints. However, there was no clinical evidence to support the efficacy of topical NSAIDs for the use of osteoarthritis of the spine. As the employee’s pain is primarily generated by the spine, use of this agent would not be supported. The requested topical agent also contains lidocaine. California Medical Treatment Utilization Schedule does not recommend the use of lidocaine in a topical cream, as this is not supported by FDA recommendations. The requested topical agent also includes amitriptyline. The clinical documentation that was submitted for review does not support that the employee has failed to respond to oral medications. As the use of the elements of this topical analgesic is not supported by guideline recommendations, its use would not be indicated. **The request for Flurbiprofen (NAP) cream-Lidocaine/Amitriptyline 180gm, date of service 4/2/13 is not medically necessary and appropriate.**

**3. Gaba/Cyclo/Trama cream base 10/6/10% 180gm, date of service 4/2/13 is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The clinical documentation submitted for review did not include any clinical findings or physical exam for the requested date of service. Prior clinical notes support that the employee has chronic low back pain with radicular symptoms. California Medical Treatment Utilization Schedule states, "any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended." The requested compound contains gabapentin and cyclobenzaprine, which are not supported by guideline recommendations. Additionally, California Medical Treatment Utilization Schedule states, "many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicins, local anesthetics, anti-depressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor.)" There is little to no research to support the use of many of these agents. As tramadol is considered an opioid, the use of this medication in a topical agent would not be supported by guideline recommendations. **The request for Gaba/Cyclo/Trama cream base 10/6/10% 180gm, date of service 4/2/13 is not medically necessary and appropriate.**

**4. Laxacin 100gm, date of service 4/2/13 is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

There was no clinical documentation submitted with the request for the date of service of 04/02/2013. Prior clinical documentation submitted for review does provide evidence that the employee has low back pain with radicular symptoms. California Medical Treatment Utilization Schedule states that topical analgesics are "largely experimental in use with few randomized control trials to determine efficacy or safety." Clinical documentation submitted for review does not provide evidence that the employee is suffering from constipation. Additionally, there is no documentation to support that the employee is intolerant of an oral form of this medication. **The request for Laxacin 100gm, date of service 4/2/13 is not medically necessary and appropriate.**

**5. Somnicin 30gm, date of service 4/2/13 is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

There was no clinical documentation or evaluation submitted for the date of service of 04/02/2013. The previous evaluations submitted for review did support that the employee had low back pain with radicular symptoms. California Medical Treatment Utilization Schedule states, "any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended." The requested Somnicin 30 gm does include the medication gabapentin. Gabapentin is not supported by guideline recommendations for topical use. **The**

**request for Somnicin 30gm, date of service 4/2/13 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.

[REDACTED]

CM13-0011780