

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **12/12/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/2/2013
Date of Injury:	8/27/2011
IMR Application Received:	8/21/2013
MAXIMUS Case Number:	CM13-0014469

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Terocin lotion 2.5/25/0.025/10% #1 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/21/2013 disputing the Utilization Review Denial dated 8/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/2/2013. 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 **Terocin lotion 2.5/25/0.025/10% #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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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.

Expert Reviewer Case Summary:

The patient is a 44-year-old male who reported a work-related injury on 08/27/2011 due to lifting a heavy object. The patient was diagnosed with lumbosacral sprain. The patient underwent L3-4 laminotomy and microdiscectomy in 2011. An unofficial MRI study of the lumbar spine dated 04/13/2012 revealed recurrent disc protrusion at L3-4, moderate to severe spinal stenosis, and facet arthropathy from L3-4 to L5-S1. The patient has underwent multiple acupuncture treatments and has used a TENS home unit.

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 Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for Terocin lotion 2.5/25/0.025/10% #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, Gabapentin (Neurontin), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-113, which is part of the MTUS.

Rationale for the Decision:

Clinical note dated 07/25/2013 noted the employee's condition had not improved significantly and had presented with a low back spasm/pain flare that had lasted 4 days. The employee reported his pain was in the lumbar spine and rated it as 8/10 to 10/10. The employee reported sneezing and having an acute increase in low back with a sharp pain/spasm into the left leg. Physical exam noted lumbar extension was measured at 0 degrees, lumbar flexion was 20 degrees, left lateral bending was at 20 degrees, and right lateral bending was at 20 degrees. Sensation was decreased in the L3 dermatome and straight leg raise was negative. Lumbar spine motor strength was 5/5 to the employee's hip flexion, hip extension, knee extension, knee flexion, ankle eversion, ankle inversion, and extensor hallucis longus. Reflexes were equal and symmetric bilaterally in the upper and lower extremities. The employee was diagnosed with lumbar postlaminectomy syndrome and myalgia, myositis. The employee stated he continued acupuncture care with noted improvement in pain and function. A trial of Terocin cream was recommended due to the employee having past difficulty with oral medications. Prescriptions for gabapentin and tizanidine were also given to the employee. The California Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least 1 drug (or drug class that) is not recommended. Terocin cream contains methyl salicylate, capsaicin, menthol, and lidocaine hydrochloride. Regarding topical lidocaine, the California Medical Treatment Guidelines recommend a trial of this medication for localized peripheral pain after there has been evidence of a trial of first-line therapy of tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica. Topical lidocaine has been designated for orphan status by the FDA for neuropathic pain. There was no clinical documentation submitted that stated the employee exhibited any signs or symptoms or neuropathic pain. Topical capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There was no clinical documentation stating how the employee responded to other treatments or how the employee was intolerant of other treatments. Guidelines state that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As such, the request for Terocin lotion is non-certified. **The request for Terocin lotion 2.5/25/0.025/10% #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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/ldh

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.