
Notice of Independent Medical Review Determination

Dated: 10/8/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/12/2013

10/25/2012

7/15/2013

CM13-0001478

- 1) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm patches **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Dendracin **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Terocin **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/15/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/17/2013. 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 Lidoderm patches **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Dendracin **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Terocin **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 Physical Medicine and Rehabilitation 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 12, 2013

"According to the records made available for review, this is a 46-year-old female, s/p injury 10/25/12. The patient most recently (7/3/13) presented with neck and low back pain. Physical examination revealed decreased L/S ROM, TTP over the lumbar spine, decreased C/S ROM, and tenderness over the C/S. Current diagnoses include cervical radiculitis, cervical sprain/strain, and shoulder sprain/strain. Treatment to date includes TENS unit, chiropractic treatment, and medications. Treatment requested is Lidoderm patches, Dendracin and Terocin."

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 (dated 7/15/2013)
- Utilization review from [REDACTED] (dated 7/11/2013)
- Medical Records from [REDACTED] (dated 10/18/12-11/27/12)
- Medical records from [REDACTED] (dated 1/2/13-3/13-13)
- Medical records from Dr. [REDACTED] (dated 4/5/13-4/18/13)
- Medical records from [REDACTED] (dated 4/11/13-6/1/13)

- Medical records from Dr. [REDACTED], DC (dated 5/3/13)
- Medical records from [REDACTED], PA-C (dated 6/4/13-7/12/13)
- Medical records from [REDACTED] (dated 6/17/13)
- Chronic Pain Medical Treatment Guidelines (May, 2009) Part 2, Interventions and Treatments pgs. 46-47, 111-113

1) Regarding the request for Lidoderm patches:

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), pgs. 56-57, 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 the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on October 25, 2012 resulting in neck and low back pain. The employee was diagnosed with cervical radiculitis, cervical sprain/strain, and shoulder sprain/strain. Treatments have included chiropractic treatment, TENS unit, and medication management. The request is for Lidoderm patches.

The MTUS Chronic Pain guidelines recommend Lidoderm patches for peripheral pain after a trial of tricyclic antidepressant (TCA), serotonin-norepinephrine reuptake inhibitor (SNRI) or anti-epileptic drug (AED) also known as first-line therapy. The medical records submitted for review show that the employee has only received non-steroidal anti-inflammatory drug and muscle relaxants which do not meet the guideline criteria for first-line therapy. The request for Lidoderm patches is not medically necessary and appropriate.

2) Regarding the request for Dendracin:

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), 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 the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on October 25, 2012 resulting in neck and low back pain. The employee was diagnosed with cervical radiculitis, cervical sprain/strain, and shoulder sprain/strain. Treatments have included chiropractic treatment, TENS unit, and medication management. The request is for Dendracin.

The MTUS Chronic Pain guidelines recommend Dendracin for pain after a trial of anticonvulsants, and/or antidepressants had failed for pain management. The medical records submitted for reviews indicate that the employee has only received non-steroidal anti-inflammatory drug (NSAIDs) and muscle relaxants which does not meet guideline criteria for first-line therapy. Therefore, the request for Dendracin is not medically necessary and appropriate.

3) Regarding the request for Terocin:

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), pg.112-113, 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 the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on October 25, 2012 resulting in neck and low back pain. The employee was diagnosed with cervical radiculitis, cervical sprain/strain, and shoulder sprain/strain. Treatments have included chiropractic treatment, TENS unit, and medication management. The request is for Terocin.

The MTUS Chronic Pain guidelines state that all topical analgesics are only recommended after failure of antidepressants or anticonvulsants. Additionally, MTUS does not recommend topical lidocaine, which is in Terocin, other than in the Lidoderm patch form. The medical records submitted for review indicate that the employee has only received non-steroidal anti-inflammatory drug (NSAIDs) and muscle relaxants which does not meet guideline criteria for first-line therapy. The request for Terocin lotion 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, 18th Floor
Oakland, CA 94612

/hs

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.