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**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]

7/5/2013

8/24/2000

7/22/2013

CM13-0002287

- 1) MAXIMUS Federal Services, Inc. has determined the request for Promolaxin 100mg #100 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Terocin lotion 120ml **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 4 pairs of TENS pads **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 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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 Promolaxin 100mg #100 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Terocin lotion 120ml **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 4 pairs of TENS pads **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 Preventative 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:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 5, 2013:

"██████████ is a 58 year old (DOB: ██████████) female, employed by ██████████, with a date of injury on 08/24/00. The carrier has accepted: Upper Back Area, Multiple Neck injury, Knees (Both). Multiple Upper Extremities, Shoulders (Both), Hands (Both), Foot (Left), Hips (Both), Lower Leg (Left), Upper Leg (Left), Buttocks and Lumbar and/or Sacral Vertebrae. The current work status is: Not addressed."

### 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 7/22/13)
- Utilization Review Determination from ██████████ (dated 7/05/13)
- Employee Medical Records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for Promolaxin 100mg #100:**

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), page 88, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), page 77, which is part of the MTUS.

Rationale for the Decision:

The employee was injured 8/24/2000 and has experienced chronic low back pain and elbow tenosynovitis. The employee has been diagnosed with myofascial pain syndrome. Treatment has included analgesic medications, multiple trigger point injection procedures, and therapeutic ultrasound. A request was submitted for Promolaxin 100mg #100.

The MTUS Chronic Pain Medical Treatment Guidelines recommend laxatives such as docusate (Promolaxin) as part of prophylactic treatment of constipation in patients using opioids chronically. The records submitted and reviewed do not include evidence that the employee is using opioids, either acutely or chronically. Further, there is no specific mention of symptoms or side effects of constipation, either standalone or the result of opioid usage. Using Promolaxin in the absence of any documented opioid usage and in the absence of any documented symptoms of constipation is not indicated. The request for Promolaxin 100mg #100 **is not medically necessary and appropriate.**

**2) Regarding the request for Terocin lotion 120ml :**

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 section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 28 and 111, which are part of the MTUS.

Rationale for the Decision:

The employee was injured 8/24/2000 and has experienced chronic low back pain and elbow tenosynovitis. The employee has been diagnosed with myofascial pain syndrome. Treatment has included analgesic medications, multiple trigger point injection procedures, and therapeutic ultrasound. A request was submitted for Terocin lotion 120ml.

The MTUS Chronic Pain Medical Treatment Guidelines indicate that capsaicin is recommended only as a last-line agent, to be reserved for patients who are intolerant to and/or have failed to respond to other treatments. Terocin is an

amalgam of methyl salicylate, capsaicin, menthol, and lidocaine hydrochloride. The records submitted and reviewed do not include evidence that the employee has tried and/or failed to respond to conventional first-line oral analgesics. Since the capsaicin component of Terocin has an unfavorable recommendation, the entire compound, per guidelines, is not recommended. The request for Terocin lotion 120ml **is not medically necessary and appropriate.**

### 3) Regarding the request for 4 pairs of TENS pads

#### 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), page 114-116, which are part of the California 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 8/24/2000 and has experienced chronic low back pain and elbow tenosynovitis. The employee has been diagnosed with myofascial pain syndrome. Treatment has included analgesic medications, multiple trigger point injection procedures, and therapeutic ultrasound. A request was submitted for 4 pairs of TENS pads.

The Chronic Pain Medical Treatment Guidelines indicate that criteria for TENS include documentation of chronic intractable pain of greater than three months' duration, evidence that other appropriate pain modalities have been tried and/or failed, and evidence of a successful one-month TENS trial. The records submitted and reviewed do not document successful prior response to the TENS unit. Further, the employee continues to be reliant on various forms of medical treatment, including trigger point injections, which does not support functional improvement. Overall, the documentation fails to support the requested TENS unit supplies. The request for 4 pairs of TENS pads **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

/sab

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.