

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/6/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/16/2013
Date of Injury:	3/13/2007
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004889

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 Prescription of Terocin Lotion 4oz #1 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 Prescription of Dendracin cream **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 1 Prescription of Cymbalta 60mg #30 with 1 refill **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 1 Prescription of Terocin Lotion 4oz #1 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 Prescription of Dendracin cream **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 1 Prescription of Cymbalta 60mg #30 with 1 refill **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.

Expert Reviewer Case Summary:

This patient is a 47-year-old male who reported an injury on 03/13/2007. The documentation submitted for review indicates the patient to have ongoing neck and back pain with a degree of severity based upon the day. Notes indicate that the patient's medications include Norco 10/325 mg, Robaxin, and Cymbalta 30 mg. Additional treatment for the patient includes a home exercise program as well as utilization of a TENS unit and lumbar epidural steroid injections performed on 01/11/2013 which provided some benefit for a few days as well as a cervical epidural steroid injection approximately 1 and a half years prior to 05/03/2013 which provided no significant benefit. Also, notes indicate the patient sees a chiropractor approximately once per week which helps reduce the patient's pain. Also, the patient is noted to be currently seeing a pain specialist. The most recent evaluation of the patient submitted for review is dated 05/03/2013. Notes indicate that the patient had subjective complaints of neck and back pain verbalized as 6/10 to 7/10 VAS. The patient also endorsed right lower extremity numbness and tingling at the foot as well as bilateral upper extremity numbness, tingling, and pain extending to the elbows. Notes indicate that the patient received significant benefit from his medications, with objective clinical findings of the patient noting a normal nonantalgic gait, with the patient able to complete heel to toe walking without difficulty. Range of motion of the cervical and lumbar spine was decreased throughout all planes and there was decreased sensation in a left C5 and C6 dermatome to pinprick and light touch, sensation intact to the bilateral lower extremities and 5-/5 strength of the left deltoid, biceps, bilateral internal and external rotators, left wrist extension, wrist flexion, and bilateral triceps. 5-/5 strength was also noted to the

right wrist in extension and flexion. The tibialis anterior and extensor hallucis longus strength was graded as 5-/5 on the right and 5/5 on the left with otherwise 5/5 strength noted in the lower extremities. The most recent treatment plan notes indicated the recommendation to continue with chiropractic treatment and a request was made for an interlaminar epidural steroid injection at C5-6 due to diagnostic as well as therapeutic properties of the injection.

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 Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for 1 Prescription of Terocin Lotion 4oz #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, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pg. 105 and 111-113 which is part of the MTUS.

Rationale for the Decision:

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 trails of antidepressants and anticonvulsants have failed. Terocin lotion is a compounded topical analgesic consisting of methyl salicylate 25%, Capsaicin 0.025%, menthol 10%, and Lidocaine 2.50%. The medical records provided for review indicate that the employee is currently prescribed Cymbalta; however, there is a lack of documentation indicating the employee has failed with trial of this antidepressant medication. Additionally, MTUS Chronic Pain Medical Treatment Guidelines indicate that Lidocaine, while recommended for a localized peripheral pain after there has been evidence of a first line trial therapy, with tricyclic or Serotonin- Norepinephrine Reuptake Inhibitor (SNRI) antidepressants or an Antiepileptic Drug (AED) such as Gabapentin or Lyrica, indicates that Lidocaine is recommended in a transdermal patch for the treatment of neuropathic pain. Other formulations of Lidocaine in a topical application without a patch are primarily indicated as local anesthetics and antipyretics. Furthermore, there is a lack of indication by the MTUS Chronic Pain Medical Treatment Guidelines for necessity of a topical formulation of Lidocaine at 2.50%. Additionally, there is lack of clear clinical rationale indicating necessity for the administration of 2 concurrent topical analgesics or failure of the employee's currently prescribed Cymbalta. **The request for Terocin lotion 4 oz #1 is not medically necessary and appropriate.**

2) Regarding the request for 1 Prescription of Dendracin cream:
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, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, Salicylate Topicals, pg. 105 and 111-113, which is part of MTUS.

Rationale for the Decision:

Dendracin cream is a salicylate topical consisting of methyl salicylate 30%, menthol 10%, and Capsaicin 0.025%. MTUS Chronic Pain guidelines indicate 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. The medical records provided for review indicate that the employee is currently prescribed Dendracin cream as well as Terocin lotion. There is no clear clinical rationale for addressing medical necessity for two concurrent topical analgesics. The Chronic Pain guidelines indicate the recommendation for a topical salicylate as being significantly better than placebo in chronic pain. However, the medical records provided for review demonstrate a lack of documentation indicating functional response of the employee to the topical analgesic. Also, there is no indication of failure of the employee's currently prescribed Cymbalta. **The request for Dendracin cream is not medically necessary and appropriate.**

3) Regarding the request for 1 Prescription of Cymbalta 60mg #30 with 1 refill:
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, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Selective Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs), pg.15 which is part of MTUS.

Rationale for the Decision:

California MTUS Guidelines indicate that selective serotonin and norepinephrine reuptake inhibitors (SNRIs) such as Cymbalta are FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia with off label use for neuropathic pain and radiculopathy. Duloxetine is recommended as a first line option for diabetic neuropathy. The medical records provided for review indicate that the employee is currently prescribed Cymbalta 30 mg for use once per day. Additionally, the medical records provided for review detail that the employee received significant benefit from the current medication regimen inclusive of Cymbalta 30 mg. There is no clear clinical rationale provided of the necessity to increase the patient's current dosage given that notes indicate benefit from the medication regimen as prescribed. **The request for Cymbalta 60 mg #30 with 1 refill 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

/ejf

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.