MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 11/14/2013

[redacted]

[redacted]

Employee:	[redacted]
Claim Number:	
Date of UR Decision:	7/15/2013
Date of Injury:	4/8/2009
IMR Application Received:	7/31/2013
MAXIMUS Case Number:	CM13-0005111

1) MAXIMUS Federal Services, Inc. has determined the request for **Terocin 240ml is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Flubiprofen 180gms is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **follow-up consult with urologist is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/19/2013. 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 240ml is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Flubiprofen 180gms is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **follow-up consult with urologist 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.

Expert Reviewer Case Summary:

The patient is a 55-year-old male who reported an injury on 04/08/2009. Pain management consultation report dated 08/01/2012 reported that the patient was previously injured due to lifting/catching a falling object. The patient had been previously treated with 2 lumbar spine laminectomy procedures. The patient complained of low back pain radiating down the left lower extremity with associated numbness and weakness. The patient denied any changes in bowel or bladder control. The patient's medications included Percocet, Ambien, Soma, Prilosec, Lidoderm patch, lisinopril, lovastatin, Wellbutrin, and Xanax. The patient was recommended for spinal cord stimulator and ongoing medication management, as well as to start Butrans patches. QME dated 12/04/2012 reported the patient complained of 5-6/10 low back pain. The provider reported that there was an agreement with the claimant's treating provider for anterior lumbar interbody fusion. Operative report dated 02/14/2013 reported the patient underwent lumbar fusion at L3-S1. Clinical note dated 03/18/2013 reported the patient followed up stating that he had problems with bowel and bladder. Follow-up on 05/21/2013 reported the patient had continued complaints of complications with urinating and continued constipation. The patient also complained of continued low back pain with painful range of motion and abdominal pain. The patient was seen by Dr. [redacted] on 06/12/2013 and diagnosed with constipation. The patient's medications at the time included Soma, Ambien, Prilosec, Lidoderm patch, Norco, gabapentin, diclofenac, Xanax, lisinopril, lovastatin, and Laxacin.

Clinical note dated 06/13/2013 reported the patient had complaints of constipation. The note reported the patient was seen by urologist with reported decreased sensation with urination. The patient was recommended for GI consult, therapy, and follow-up with urology. Utilization determination letter dated 07/15/2013 reported request for Terocin lotion, flurbiprofen, and follow-up consult with urologist were non-certified.

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

1) **Regarding the request for Terocin 240ml:**

   Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
   The Claims Administrator did not cite a guideline in its utilization review determination letter.

   The Expert Reviewer based his decision on the Chronic Pain Medical Treatment Guidelines, topical Analgesics, pgs. 111-112, which is part of the MTUS.

   Rationale for the Decision:
   The request for Terocin was previously non-certified on 07/15/2013 due to unknown rationale. However, guidelines state topical creams are largely experimental in use with few randomized controlled trials documenting their safety and efficacy. Terocin lotion includes methyl salicylate, capsaicin, menthol, and lidocaine. There was a lack of a recent clinical note submitted for review providing the clinical rationale for the proposed Terocin cream. The employee is taking numerous oral medications and there is no indication why the employee would require topical cream versus continuation of oral medications. In addition, guidelines state there is no other commercially approved topical formulation of lidocaine, with the exception of Lidoderm patches. **The request for Terocin 240ml is not medically necessary and appropriate.**

2) **Regarding the request for Flubiprofen 180gms:**

   Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
   The Claims Administrator did not cite a guideline in its utilization review determination letter.

   The Expert Reviewer based his decision on the Chronic Pain Medical Treatment Guidelines, topical Analgesics, pg. 111, which is part of the MTUS.

Rationale for the Decision:
The request was previously non-certified for unknown rationale. Chronic Pain Medical Treatment Guidelines state compounded topical creams are largely experimental in use with few randomized trials. Flurbiprofen is an NSAID medication that is recommended for mild to moderate osteoarthritis pain. The documentation submitted for review fails to indicate the employee has osteoarthritis pain. There is no indication that the employee would require topical NSAID versus standard oral medications. **The request for Flubiprofen 180gms is not medically necessary and appropriate.**

3) **Regarding the request for follow-up consult with urologist:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his decision on the American College of Occupational and Environmental Medicine Guidelines (ACOEM), 2nd Edition, (2004), Cornerstones of Disability Prevention and Management, pgs 89-92, which is part of the MTUS.

Rationale for the Decision:
The request for follow-up consult with urologist was previously non-certified from unknown rationale. The documentation submitted for review does not provide a clinical rationale for the proposed follow-up visit with urologist. It is unclear what treatment was recommended at the initial urology evaluation and/or the efficacy of said treatment. **the request for follow-up consult with urologist 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

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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.