

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/14/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	3/8/2011
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005526

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Teroцин lotion is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/16/2013. 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 retrospective request for **Terocin lotion 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 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.

### Expert Reviewer Case Summary:

This IW has CRPS (Chronic Regional Pain Syndrome), Major Depression, chronic low back and knee pain. She had a partial left knee meniscectomy. Her pain includes the right side of her back, her left knee with radiation to the left foreleg and foot numbness. She requires multiple medications including opiates for her pain disorder and despite them, her pain level remains high 7/10 and higher.

### 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 from Excel
- Medical Records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

### 1) Regarding the request for Terocin lotion:

#### 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, pgs. 111-112, which is part of the the MTUS.

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

Rationale for the Decision:

Topical analgesics are medically indicated for the treatment of peripheral neuropathy when trials of antidepressants and anticonvulsants have failed. There is little research to recommend them for chronic pain, as their effectiveness and safety remain ill defined. There is little evidence to recommend them for the long-term management of chronic pain. Terocin lotion contains methyl salicylate (a non-steroidal pain medicine), capsaicin, menthol (two plant derived skin irritants) and Lidocaine (a peripheral nerve anesthetic). Topical NSAIDS have a role in the short –term treatment of arthritis. These topical irritants can play an adjunctive role in muscle spasm treatment. Topical Lidocaine is indicated for treating neuropathic pain. There is negative evidence that it is effective for chronic muscle pain. **The retrospective request for Error! Reference source not found. 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, 18<sup>th</sup> 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.