

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **12/17/2013**

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/18/2013
Date of Injury: 9/25/2012
IMR Application Received: 8/6/2013
MAXIMUS Case Number: CM13-0008073

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Retro Terocin 240mL is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Retro Flurbiprofen 180G is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Retro Gabacyclotram 180G is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/11/2013. 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 **Retro Terocin 240mL is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Retro Flurbiprofen 180G is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Retro Gabacyclotram 180G 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 Internal 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:

The patient is a 40-year-old male who reported an injury on 9/25/2012. The patient's current diagnoses include headache, cervical radiculopathy, cervical sprain and strain, lumbar radiculopathy, lumbar sprain and strain, right shoulder impingement syndrome, right shoulder sprain and strain, right carpal tunnel syndrome, and right wrist sprain and strain. The most recent physical examination dated 7/25/2013 noted objective findings including tenderness to palpation of bilateral upper trapezius, cervical paravertebral muscles, lumbar paravertebral muscles, acromioclavicular joint, anterior shoulder and supraspinatus, and dorsal wrist. Objective findings also included positive shoulder depression testing bilaterally, positive straight leg raising bilaterally, positive Neer's testing on the right, and positive Phalen's testing on the right. Treatment plan included chiropractic manipulation.

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:

[REDACTED]

1) Regarding the request for Retro Terocin 240mL:

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, page 111, which is part of MTUS, and the Official Disability Guidelines (ODG), Topical Analgesics Section, which is not part of MTUS.

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

Rationale for the Decision:

The Chronic Pain guidelines state topical analgesics are recommended as an option and are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. Terocin cream is a combination of methyl salicylate, capsaicin, menthol, and lidocaine. Topical lidocaine, in the formulation of a dermal patch, has been designated for neuropathic pain by the FDA. No other commercially-approved topical formulation of lidocaine is indicated for neuropathic pain. The clinical information submitted for review fails to provide evidence of a failure to respond to antidepressants or anticonvulsants prior to the request for an initiation of a topical analgesic. **The request for Retro Terocin 240mL is not medically necessary and appropriate.**

2) Regarding the request for Retro Flurbiprofen 180G:

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, pages 105, 112, 113, which is part of MTUS, and the Official Disability Guidelines (ODG), Topical Analgesics Section, which is not part of MTUS.

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

Rationale for the Decision:

The Chronic Pain guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Indications for topical non-steroidal anti-inflammatory drugs (NSAIDs) include osteoarthritis and tendinitis, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use, including 4 to 12 weeks. The records submitted for review do not include documentation providing evidence of a failure to respond to first-line treatment, prior to the request for a topical analgesic. **The**

request for Retro Flurbiprofen 180g is not medically necessary and appropriate.

3) Regarding the request for Retro Gabacyclotram 180G:

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, page 111, which is part of MTUS, and the Official Disability Guidelines (ODG), Topical Analgesics Section, which is not part of MTUS.

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

Rationale for the Decision:

The Chronic Pain guidelines state topical analgesics are recommended as an option for neuropathic pain when trials of antidepressants and anticonvulsants have failed. They are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug that is not recommended is not recommended as a whole. Gabapentin is not recommended for topical application, as there is no peer-reviewed literature to support topical use. As such, the request for compounded Gabacyclotram 180 grams is also not supported in the guidelines. **The request for Retro Gabacyclotram 180g 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

/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.