

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/22/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/15/2013
Date of Injury:	9/25/1997
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003117

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of Paxil 40mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Teracin lotion 0.5-0.025 – 10-25% **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 Paxil 40mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Teracin lotion 0.5-0.025 – 10-25% **is not medically necessary and appropriate.**

### Medical Qualifications of the Expert Reviewer:

The expert reviewer 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.

### Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 16, 2013:

“The patient is a 61 year old female with a date of injury of 9/25/1997. The provider has submitted a prospective request for one C2-3 and C3-4 bilateral facet injection, one prescription of Paxil 40mg, one prescription of Celebrex 200mg #60, one prescription of Terocin lotion 0.5-0.025 · 1.0-25%, and one bilateral C2 block. According to documentation submitted, the patient is being treated for chronic daily headaches as well as neck pain and bilateral knee pain. Neck pain is ongoing since the neck surgery, and is described as pain radiating to the top of bilateral shoulders with accompanying spasms. Headaches have been present for over two years, are rated 9/10, and begin at the base of the occiput with radiation to the parietal region with associated retro orbital pressure. As per the progress report dated 7/9/2013, the patient also reported depression secondary to headache and neck pain. Significant objective findings on 7/9/2013 consisted of cervical paraspinal tenderness, painful neck rotation bilaterally, facet joint tenderness from C2-3 through C4-5 bilaterally, pain with cervical spine extension, pain to palpation over the C2 transverse processes bilaterally, headache reproduced with palpation over the C2 region, and negative foraminal closure tests bilaterally. The patient was diagnosed with occipital neuralgia, cervicalgia, and depression. The provider is requesting cervical facet injections at this time.”

### 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 dated 7/25/2013
- Utilization Review Determination from [REDACTED]

- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request 1 prescription of Paxil 40mg :**

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), Antidepressants, pages 13-16, 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 on 9/25/1997 and complains of intermittent neck pain, constant and moderate intensity low back pain, and knee pain. Medical records provided for review indicate a two level cervical fusion in March 2012. Treatment includes both oral and topical medications. A request was submitted for Paxil 40 mg.

The Chronic Pain Medical Treatment Guidelines indicate that Paxil is an antidepressant and can be recommended as a treatment first-line for neuropathic pain, as a possibility for non-neuropathic pain. Tricyclic antidepressants are generally considered a first-line agent unless they are ineffective, poorly tolerated or contraindicated. Paxil is described as a selective serotonin reuptake inhibitor (SSRI). Tricyclic antidepressants are recommended over SSRIs unless adverse reactions are a problem. The records submitted and reviewed do not document that the employee has been trialed on a tricyclic antidepressant. In addition, the records indicate that no substantial benefit has been experienced from taking this medication for an extended period of time, and there has been no documented psychiatric evaluation to document depression or anxiety. The request for Paxil 40 mg **is not medically necessary and appropriate.**

2) **Regarding the request for Teracin lotion 0.5-0.025 – 10-25%:**

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 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 on 9/25/1997 and complains of intermittent neck pain, constant and moderate intensity low back pain, and knee pain. Medical records provided for review indicate a two level cervical fusion in March 2012. Treatment

includes both oral and topical medications. A request was submitted for Teracin lotion 0.5-0.025 – 10-25%.

The Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are “largely experimental in use with few randomized controlled trials to determine efficacy or safety.” Teracin lotion contains methyl salicylate, capsaicin, menthol, and lidocaine hydrochloride. The guidelines indicate that lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of a first-line therapy such as a tricyclic or SNRI antidepressants or a medication such as gabapentin or Lyrica. The guidelines indicate that capsaicin is recommended as an option in patients who have not responded or who are intolerant to other treatments. The records submitted and reviewed do not demonstrate the employee has been intolerant to other treatments, or that there has been a trial on a tricyclic or SNRI antidepressant. Further, the records do not evidence a trial on gabapentin or that it has failed. The request for Teracin lotion 0.5-0.025 – 10-25% **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.