

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/11/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/3/2013
Date of Injury:	12/8/2011
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0006000

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

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/22/2013. 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 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 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:

The patient is a 36-year-old male who reported an injury on 12/08/2011. Diagnoses include left shoulder pain, left shoulder AC joint arthropathy, left shoulder rotator cuff tear, and myalgia/myositis. The patient was most recently seen by Dr. [REDACTED] on 06/01/2013. Objective findings included tenderness to palpation of the cervical spine, muscle spasms, negative Spurling's and Adson testing, tenderness to palpation in the left shoulder, positive impingement testing on the left, and intact sensation. The patient was diagnosed with left shoulder pain, left shoulder AC joint arthropathy, left shoulder rotator cuff tear, and myalgia myositis. Treatment plan included continuation of current medications and continuation of pain management. A Utilization Review Report was submitted on 07/03/2013 by Dr. [REDACTED]. The requests for tramadol, tizanidine, and ibuprofen were certified, and the request for Terocin lotion was 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
- Medical Records from Claims Administrator
- 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, Pain, Topical Analgesics Lidocaine, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Page 111-113, which is part of MTUS.

Rationale for the Decision:

California MTUS 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. Terocin lotion is comprised of methyl salicylate, capsaicin, menthol, and lidocaine. Lidocaine patch is the only formulation recommended per evidence-based medicine. A compounded product that contains at least 1 drug that is not recommended is then not recommended as a whole. According to the medical records provided for review, there is no documentation of a failure to respond to anti-depressants and anticonvulsants prior to the initiation of a topical analgesic. **The request for Terocin lotion 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.