

<b>Case Number:</b>	CM13-0052037		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/06/2012
<b>Decision Date:</b>	02/21/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This female patient sustained an injury on 2/6/12 while employed. Requests under consideration include Terocin patches, transdermal cream and rubs, and physical therapy twice a week for six weeks. Diagnoses include left shoulder internal derangement with early adhesive capsulitis. Report dated 9/23/13 from [REDACTED] noted electrodiagnostic test on August 13th showed mild right-sided carpal tunnel syndrome and left C6 radiculopathy. Patient was approved for 6 sessions of PT. Exam noted tenderness over AC joint and glenohumeral joint; shoulder flex and abduction 140, ER 60 and IR 75 degrees, all with pain. Diagnoses were left shoulder impingement syndrome with residual pain and emotional weakness. Treatment included additional PT before considering arthroscopy. It was noted the patient had cervical radiculopathy on left and CTS with recommendation for Terocin patches and continue patient's oral medications. Requests were non-certified on 10/16/13 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Terocin patches:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** This female patient sustained an injury on 2/6/12 while employed. Report dated 9/23/13 from [REDACTED] noted electrodiagnostic test on August 13th showed mild right-sided carpal tunnel syndrome and left C6 radiculopathy. Exam showed tenderness of shoulder with limited range from pain. No neurological exam findings were noted. Diagnoses were left shoulder impingement syndrome with residual pain and emotional weakness. It was noted the patient had cervical radiculopathy on left and CTS with recommendation for Terocin patches and continue patient's oral medications. Per manufacturer, Terocin is Methyl Salicylate 25%, Menthol 10%, Capsaicin 0.025%, Lidocaine 2.5%, Aloe, Borage Oil, Boswelia Serrata, and other inactive ingredients. Per MTUS, medications should be trialed one at a time and is against starting multiples simultaneously. In addition, Boswelia Serrata and topical Lidocaine are specifically "not recommended" per MTUS. Per FDA, topical Lidocaine as an active ingredient in Terocin is not indicated and places unacceptable risk of seizures, irregular heartbeats and death on patients. The provider has not submitted specific indication to support this medication outside of the guidelines nor is there any documented functional improvement from treatment already rendered for this February 2012 injury. The Terocin patches are not medically necessary and appropriate.

**Transdermal cream and rubs:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** This female patient sustained an injury on 2/6/12 while employed. Report dated 9/23/13 from [REDACTED] noted electrodiagnostic test on August 13th showed mild right-sided carpal tunnel syndrome and left C6 radiculopathy. Exam showed tenderness of shoulder with limited range from pain. No neurological exam findings were noted. Diagnoses were left shoulder impingement syndrome with residual pain and emotional weakness. It was noted the patient had cervical radiculopathy on left and CTS with recommendation for Terocin patches and continue patient's oral medications. Submitted reports have not specified what transdermal creams and rubs are being requested or its indication and necessity for this 2012 injury with chronic pain with the patient already taking multiple other oral medications. There is no demonstrated functional improvement from ongoing refills of medication. Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this unspecified topical analgesic. The transdermal cream and rubs is not medically necessary and appropriate.

**Physical therapy twice a week for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

**Decision rationale:** This female patient sustained an injury on 2/6/12 while employed. Report dated 9/23/13 from [REDACTED] noted electrodiagnostic test on August 13th showed mild right-sided carpal tunnel syndrome and left C6 radiculopathy. The patient was recently approved for 6 PT visits. Exam showed tenderness of shoulder with limited range from pain. No neurological exam findings were noted. Diagnoses were left shoulder impingement syndrome with residual pain and emotional weakness. It was noted the patient had cervical radiculopathy on left and CTS with recommendation for Terocin patches and continue patient's oral medications. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received some previous therapy sessions reports and current request is for additional PT. Submitted reports have not adequately demonstrated the indication to support further physical therapy. The physical therapy twice a week for six weeks is not medically necessary and appropriate.