

Case Number:	CM13-0055357		
Date Assigned:	12/30/2013	Date of Injury:	06/28/2001
Decision Date:	07/25/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	11/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert 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 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 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:

The injured worker is a 58-year-old female who reported an injury on 06/28/2001. The mechanism of injury was not specifically stated. Current diagnoses include lumbago, right leg sciatica, rotator cuff tear, depression, right-sided sacroiliitis, right femoral acetabular impingement, left knee pain, and left knee arthritis. The injured worker was evaluated on 10/04/2014 with complaints of left knee pain, neck pain, leg pain, and shoulder pain. Previous conservative treatment includes medication management, physical therapy, and aquatic therapy. Physical examination revealed noticeable atrophy of the deltoid, supraspinatus and infraspinatus muscle with 3/5 strength testing, positive impingement testing, positive straight leg raising on the right, positive FABER testing on the right, 0 to 120 degree left knee range of motion, positive McMurray's testing, positive Apley's compression and distraction testing, a large palpable baker's cyst, and painful right hip range of motion. Treatment recommendations included prescriptions for Terocin patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTION OF TEROGIN PATCHES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no strength, frequency, or quantity listed in the current request. Therefore, the requested Terocin Patches are not medically necessary.