

Case Number:	CM13-0063287		
Date Assigned:	12/30/2013	Date of Injury:	08/03/2011
Decision Date:	04/04/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/09/2013

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, has a subspecialty in Pain 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 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:

The patient is a 44 year old male who was injured on 08/03/2011. The patient sustained an injury to the left foot with unknown mechanism of injury. Prior treatment history has included bone stimulation. The patient was given a knee scooter but also utilizes a cam walker boot when ambulating. The patient underwent subtalar joint arthrodesis on 08/08/2013. Clinic note dated 10/30/2013 indicated the patient states that all of his pain is at the plantar aspect of the heel only and not at the ankle, which he experienced on the last encounter. He states that he is still limping, but that everyday there seems to be a little more noticeable improvement. He has also noticed some atrophy of his calf, which has been improving since he has started walking. Objective findings on examination of the left foot include his neurovascular status appeared intact and unchanged since prior to surgery. There was no evidence of neuritis, numbness or neuropathy. There was minimal edema present. There was no erythema or obvious inflammation at the surgical site. The scar is so faint that it is barely visible. There was no evidence of any complication whatsoever at the surgical site. There was no pain on palpation at the lateral aspect of foot along the surgical site. There was no pain on palpation or on ROM of and the ankle joint. The patient was diagnosed with sinus tarsi syndrome, left foot, possible fractured tarsal coalition at the calcaneonavicular level, left foot, degenerative joint disease of the subtalar join left foot, pain and difficulty in ambulation secondary to the above.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Terocin for treatment of ankle: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-112.

Decision rationale: As per the guidelines, topical analgesics are largely experimental in use and efficacy has not been established. Lidocaine, which is the primary component of Terocin patch is not recommended for non-neuropathic pain. The medical records do not establish the claimant has neuropathic pain or that he has failed a trial of first line therapy. Furthermore, according to the 10/30/2013, the patient acknowledges that his condition is improving, and examination at that time documented there was no evidence of neuropathy. The medical necessity of Terocin (unknown quantity, twice daily), has not been established.