

Case Number:	CM14-0007704		
Date Assigned:	02/10/2014	Date of Injury:	09/16/2011
Decision Date:	06/09/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/17/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 patient is a 48 year old female who sustained an injury on 09/16/11 while emptying a waste bag. The patient felt pain in the low back radiating to the right groin and hip. Initial treatment included physical therapy and medications with no improvement. The patient also received one injection to the right hip with anesthesia that did not provide any improvements in pain. MRI of the right hip from 02/20/12 showed degenerative changes in the right hip joint with fraying in undersurface tearing of the labrum. Given the failure of conservative treatment which included additional physical therapy and epidural steroid injections with no response, the patient underwent arthroscopic labral repair and acetabular takedown with femoral neck resection on 05/06/13. Post-operatively the patient noted pain with right hip range of motion on flexion,adduction, and internal rotation. The patient was seen on 09/17/13 with continuing complaints of intermittent right hip pain and constant low back pain. Physical examination showed limited range of motion in the low back and right hip. The patient was prescribed Percocet and Xanax as well as given a topical compounded medication that included anti-inflammatories, gabapentin, and cyclobenzaprine. The patient was also prescribed glucosamine and Somnicin. Follow up on 10/09/13 reported continuing complaints of low back pain radiating to the right hip. Physical examination continued to show limited range of motion in both the lumbar spine and right hip. The patient was given a prescription for Terocin at this visit in combination with multiple compounded topical medications. There was also recommendation for electro shockwave therapy for myofascial pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEROCIN PAIN PATCH (BOX 10 PATCHES) X2: Upheld

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

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

Decision rationale: The patient was already prescribed several topical compounded medications which contained both anti-inflammatories and topical lidocaine. The primary component of Terocin is capsaicin which could be considered an option in the treatment of neuropathic symptoms when other oral medications failed. As the patient had already been prescribed multiple compounded medications including a neuropathic component, there was no indication for the use of Terocin patches in this case. Therefore, this medication is not medically necessary.

EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment Worker's Compensation, Low Back Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow Chapter, ESWT.

Decision rationale: In regards to extracorporeal shockwave therapy, current evidence based guidelines did not recommend the use of this therapy for treatment of chronic low back pain or myofascial pain. Per guidelines, this type of therapy was considered experimental/investigational for the lumbar spine or for myofascial pain. There was no indication that electro shockwave therapy had been recommended for the elbow which is the only area of the body that supports the use of electro corporeal shockwave therapy. As such, this modality is not medically necessary.