

<b>Case Number:</b>	CM14-0018847		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	03/10/2009
<b>Decision Date:</b>	08/19/2014	<b>UR Denial Date:</b>	02/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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:

This is a patient with a date of injury of March 10, 2009. A utilization review determination dated February 13, 2014 recommends non-certification of Terocin patch and Ondansetron Hydrochloride. A progress report dated January 27, 2014 identifies subjective complaints of pain in the right shoulder and wrist. The note indicates that the patient's depression is much better controlled. The patient is scheduled for subacromial decompression on February 7, 2014. The note indicates that her left shoulder and lumbar spine are not part of the claim. Physical examination identifies pain with elevation of the right upper extremity against gravity with decreased grip strength noted on the right side. The treatment plan recommends refilling the patient's medications with the addition of postoperative medications. The diagnosis is shoulder region disorders, not elsewhere classified. A utilization review determination dated January 16, 2014 recommends certification for right shoulder arthroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MED POSSIBLE RETRO TEROGIN PATCH:** Upheld

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

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

**Decision rationale:** Terocin is a combination of methyl salicylate, menthol, Lidocaine and Capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended for use. Regarding the use of topical nonsteroidal anti-inflammatory drugs, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical nonsteroidal anti-inflammatory drugs (NSAIDs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Regarding the use of Capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to, or are intolerant to other treatments. Regarding the use of topical Lidocaine, guidelines the state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. There is also no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical Lidocaine. Finally, there is no indication that the patient has been intolerant to, or did not respond to other treatments prior to the initiation of Capsaicin therapy. In the absence of clarity regarding those issues, the request is not medically necessary.

**ONDANSETRON HYDROCHLORIDE 8MG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

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

**Decision rationale:** ODG states that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Guidelines go on to recommend that Ondansetron is approved for postoperative use, nausea and vomiting secondary to chemotherapy, and acute use for gastroenteritis. Within the documentation available for review, it appears the patient has been approved and scheduled for shoulder surgery. As such, a short course of Ondansetron may be indicated to address any postoperative nausea, should it occur. Unfortunately, the current request does not include a frequency of use, duration of use, or number of pills being requested. Guidelines do not support the open-ended use of this medication on an ongoing basis. There is no provision to modify the current request. As such, the request is not medically necessary.