MAXIMUS Federal Services

| Case Number: | CM14-0121259 | | |
|---|---|---|---|
| Date Assigned: | 08/06/2014 | Date of Injury: | 03/09/2001 |
| Decision Date: | 09/16/2014 | UR Denial Date: | 07/22/2014 |
| Priority: | Standard | Application Received: | 07/31/2014 |

## 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 and is licensed to practice in Nevada. 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 records, presented for review, indicate that the injured worker is a 73-year-old individual was reportedly injured on 3/9/2001. The mechanism of injury was noted as a lifting injury. The most recent progress note, dated 7/3/2014, indicated that there were ongoing complaints of low back pain that radiated in the bilateral lower extremities. The physical examination demonstrated the patient was suffering from severe sacroiliac joint inflammation with signs and symptoms of radiculitis/radiculopathy due to the posterior lateral aspect of L5. Gaenslens and Patrick's tests were positive. Sacroiliac joint thrust demonstrated severely positive on today's exam. No recent diagnostic studies are available for review. Previous treatment included epidural steroid injections, lumbar spine surgery, and the placement of bone stimulator, physical therapy, acupuncture, and medication. A request had been made for Terocin patch #30 with 1 refill and Duragesic patch 50mcg #10 with one refill and was not certified in the pre-authorization process on 7/22/2014.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin patch transdermals #30 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 105, 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 112.

**Decision rationale:** Terocin is a topical analgesic containing lidocaine and menthol. MTUS guidelines support topical lidocaine as a secondary option for neuropathic pain after a trial of an antiepileptic drug or anti-depressants have failed. There is no evidence-based recommendation or support for menthol. MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". As such, this request is considered not medically necessary.

**Duragesic patch 50mcg transdermals #10 refills1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 93, 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 93.

**Decision rationale:** The MTUS guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Treatment guidelines specifically state fentanyl is "not recommended for musculoskeletal pain." Review, of the available medical records, fails to document improvement in pain or function with the current treatment regimen. Given the date of injury, clinical presentation and current diagnosis, this request is not considered medically necessary.