

<b>Case Number:</b>	CM14-0151115		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	12/20/2004
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 Emergency 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:

This is a female injured worker with a date of injury of 12/20/2004. The mechanism of injury was not stated. The current diagnoses include right shoulder impingement and right shoulder rotator cuff tear. Previous conservative treatment includes medication management. The current medication regimen includes Terocin pain patch and Hydrocodone 10/325 mg. The injured worker was evaluated on 07/23/2014. It is noted that the injured worker was status post MRI of the right shoulder, which indicated bursal fraying and partial disruption of a supraspinatus tendon with inflammation, as well as tendinitis of the biceps tendon and a type 2 acromion. Physical examination revealed positive impingement sign, weakness and limited range of motion. Treatment recommendations included a right shoulder arthroscopy and a prescription for Terocin patch and Hydrocodone 10/325 mg. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TEROCIN PATCH:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS Guidelines state topical analgesics are largely experimental in use

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) Guidelines state 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 initial of a topical analgesic. There is also no strength, frequency or quantity listed in the request. As such, the request is not medically appropriate.