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| Case Number: | CM14-0172507 | | |
| Date Assigned: | 10/23/2014 | Date of Injury: | 01/20/2012 |
| Decision Date: | 11/21/2014 | UR Denial Date: | 10/07/2014 |
| Priority: | Standard | Application Received: | 10/17/2014 |

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 Physical Medicine & Rehabilitation 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:

The injured worker is a 67-year-old male who reported an injury on 01/20/2012. The mechanism of injury was a fall. The diagnostic studies were not provided. The injured worker underwent a right rotator cuff repair in 04/2013. The documentation of 06/23/2014 revealed the injured worker had a massive rotator cuff repair in his right shoulder and had persistent weakness of the right shoulder. The injured worker had been experiencing pain in the left shoulder from favoring his right shoulder. The objective findings revealed persistent atrophy of the supraspinatus and infraspinatus muscle on the right with collapsing weakness on flexion and abduction. The x-rays of the left shoulder revealed the excision of the left AC joint and subacromial decompression. The injured worker had minimal weakness in abduction and forward flexion on the left side. The treatment plan included Vicodin 5/500 mg, Norco, and a cortisone injection. The note was of poor fax quality and difficult to read. The documentation indicated the injured worker was given Terocin patches to help control the pain caused because the NSAIDs and analgesics aggravated his stomach. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin 5/500mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Opioids Page(s): 60, 78, 86.

Decision rationale: The California MTUS Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Vicodin 5/500 mg #60 is not medically necessary.

Terocin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topical, Topical Analgesic, Lidocaine Page(s): 105. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:
<http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=100ceb76-8ebe-437b-a8de-37cc76ece9bb>

Decision rationale: The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical Lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per dailymed.nlm.nih.gov, Terocin patches are topical Lidocaine and Menthol. The clinical documentation submitted for review indicated the injured worker could not utilize other medications due to an aggravation of his stomach with other medications. The duration of use could not be established. There was a lack of documentation indicating a failure of first line therapy. The request as submitted failed to indicate whether the request was for Terocin lotion or Terocin patches. The physician documentation indicated the request was for Terocin patches since the injured worker got stomach upset from other medications. The request as submitted failed to indicate the frequency, strength, and quantity of medication being requested. Given the above, the request for Terocin is not medically necessary.