

Case Number:	CM14-0041569		
Date Assigned:	06/30/2014	Date of Injury:	08/31/2007
Decision Date:	09/05/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	04/07/2014

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 patient is a 48-year-old male who has submitted a claim for chronic right shoulder pain status post right shoulder open decompressive surgery associated with an industrial injury date of 08/31/2007. Medical records from 08/07/2010 to 04/01/2014 were reviewed and showed that patient complained of chronic right shoulder pain (grade not specified) with numbness into hands. Physical examination of the right shoulder revealed slightly erythematous and hypertrophic scar. Right shoulder ROM was decreased. Positive impingement sign and significant guarding was noted. Sensation to light touch was decreased over the right C5 dermatomal distribution. MRI of the right shoulder dated 02/21/2014 revealed possible supraspinatus, infraspinatus, and subscapularis tendinosis and prior acromioplasty/subacromial decompression. Treatment to date has included rotator cuff repair, Neer's acromioplasty, clavicle undersurface resection, bicipital tenosynovectomy and repair, and coracoacromial ligament resection from the subdeltoid bursa, right shoulder (02/12/2008), open right shoulder surgery (11/08/2011), physical therapy, and pain medications. Utilization review dated 03/10/2014 denied the request for TENS unit trial because there was no documentation of participation in a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit - body part not specified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Transcutaneous electrotherapy Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

Decision rationale: According to the MTUS Chronic Pain Treatment Guidelines, TENS is not recommended as a primary treatment modality. A trial of one-month home-based TENS may be considered as a noninvasive conservative option. It should be used as an adjunct to a program of evidence-based functional restoration. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. In this case, the patient has already completed unspecified visits of postsurgical physical therapy. There was no documentation of active participation in functional restoration program by the patient. The use of TENS as primary mode of treatment is not recommended. The request likewise failed to specify the body part to be treated. It was not indicated whether the TENS unit was for rental or purchase. Therefore, the request for TENS Unit (body part not specified) is not medically necessary.

Terocin Lotion, quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain and Topical Analgesics; Topical Salicylate Page(s): 105, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 12th Edition (Web), 2014, Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, pages 28-29; Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylates.

Decision rationale: Terocin lotion contains: methyl salicylate 25%, capsaicin 0.025%, menthol 10%, and lidocaine 2.50%. MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option when there was failure to respond or intolerance to other treatments. Guidelines state that capsaicin in a 0.0375% formulation is not recommended for topical applications. Regarding the Lidocaine component, MTUS Chronic Pain Medical Treatment Guidelines identify on page 112 that topical formulations of lidocaine (whether creams, lotions or gels) are not indicated for neuropathic or non-neuropathic pain complaints. According to the guideline, topical salicylate is significantly better than placebo in chronic pain. Regarding the Menthol component, MTUS does not cite specific provisions, but the Official Disability Guidelines (ODG), Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. In this case, Terocin lotion is being prescribed as adjuvant treatment to oral medications. However, the compounded product contains lidocaine, which is not recommended for topical use. Guidelines state that any compounded product that contains at least one drug that is not recommended is not recommended. Therefore, the request for Terocin lotion, quantity 1 is not medically necessary.

