

Case Number:	CM13-0042920		
Date Assigned:	12/27/2013	Date of Injury:	12/05/2006
Decision Date:	04/10/2015	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	10/21/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 53-year-old female, who sustained an industrial injury on 12/5/06. She has reported bilateral wrist and shoulder pain after injury. The diagnoses have included myofascial pain syndrome, repetitive strain injury bilateral upper extremities, and right rotator cuff syndrome. Treatment to date has included medications, diagnostics, surgery and acupuncture. Surgeries included right shoulder and bilateral carpal tunnel release. Currently, as per the primary treating physician's progress note dated 9/3/13, the injured worker complains of pain in the right shoulder and right upper extremity especially with overhead activity. The orthopedic consult is still pending and she is currently not working. Physical exam revealed positive right shoulder impingement, decreased range of motion by 10 percent in all planes, positive scar right shoulder, and positive Tinel sign right wrist with decreased strength in right shoulder. The current medications included Naprosyn, Omeprazole, Neurontin, Zanaflex, Terocin and Dendracin. On 10/15/13 Utilization Review non-certified a request for RETROSPECTIVE (DOS: 1/8/13) TIZANIDINE 4MG, #150 THREE TIMES A DAY , RETROSPECTIVE (DOS: 1/8/13) TEROGIN LOTION 120ML, TWO TIMES A DAY and RETROSPECTIVE (DOS: 1/8/12) DENDRACIN 120ML TWO TIMES A DAY, noting the (MTUS) Medical Treatment Utilization Schedule Guidelines Chronic pain Tizanidine (Zanaflex, generic available) page 66 was cited, the (MTUS) Medical Treatment Utilization Schedule Guidelines chronic pain SALICYLATE TOPICALS pages 105, 112-113 were cited, and the (MTUS) Medical Treatment Utilization Schedule Guidelines chronic pain SALICYLATE TOPICALS pages 105, 112-113 were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE (DOS: 1/8/13) TEROGIN LOTION 120ML, TWO TIMES A DAY:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SALICYLATE TOPICALS Page(s): 105, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: Terocin lotion is formed by the combination of methyl salicylate, capsaicin, and menthol. According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended. Terocin lotion contains capsaicin a topical analgesic not recommended by MTUS. Furthermore, there is no documentation of failure or intolerance of first line oral medications for the treatment of pain. Based on the above RETROSPECTIVE request TEROGIN LOTION 120ML, TWO TIMES A DAY is not medically necessary.

RETROSPECTIVE (DOS: 1/8/13) TIZANIDINE 4MG, #150 THREE TIMES A DAY:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available) Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

Decision rationale: According to MTUS guidelines, non-sedating muscle relaxants are recommended with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient was previously treated with Tizanidine for at least more than 4 months, which is considered a prolonged use of the drug. There is no continuous and objective documentation of the effect of the drug on patient pain, spasm and function. There is no recent documentation for recent pain exacerbation or failure of first line treatment medication. Therefore, the request for RETROSPECTIVE (DOS: 1/8/13) TIZANIDINE 4MG, #150 THREE TIMES A DAY is not medically necessary.

RETROSPECTIVE (DOS: 1/8/12) DENDRACIN 120ML TWO TIMES A DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SALICYLATE TOPICALS Page(s): 105, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Section Page(s): 126.

Decision rationale: Dendracin is formed by methyl salicylate, mentol and benzocaine. According to MTUS, salicylate topicals is recommended and is better than placebo. Benzocaine (similar to lidocaine) could be recommended in neuropathic pain. There are no strong controlled studies supporting the efficacy of dendracin. Furthermore, It is not clear from the records that the failed oral first line therapies such as anticonvulsant or developed unacceptable adverse reactions from the use of these medications. Therefore, the RETROSPECTIVE request of DENDRACIN 120ML TWO TIMES A DAY is not medically necessary.