MAXIMUS Federal Services

Case Number:	CM14-0190812		
Date Assigned:	11/24/2014	Date of Injury:	11/28/2012
Decision Date:	01/09/2015	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	11/14/2014

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 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:

This 61 year-old patient sustained an injury on 11/28/12 while employed by [redacted]. Request(s) under consideration include Terocin patch, QTY: 60, Dispensed Terocin patch, QTY: 30, and MRI of Lumbar Spine. Diagnoses include cervical spondylosis; lumbosacral strain/sprain; carpal tunnel syndrome (CTS); and shoulder strain/sprain. The patient continues to treat for chronic ongoing symptoms. Medications list Prilosec, Ibuprofen, and Flexeril. There is a urine drug screen (UDS) report dated 6/2/14 with inconsistent findings of non-prescribed Hydrocodone and Hydromorphone positive. [redacted] provider report of 6/12/14 noted patient with chronic ongoing neck, shoulder, and low back pain from being rear-ended. Conservative care has included medications, physical therapy, acupuncture, and modified activities/rest. Exam showed intact findings of cervical spine; lumbar findings of normal gait; no paraspinal spasm or pain on palpation; minimal limited flexion range; positive SLR; negative Faber; 5/5 motor strength throughout lower extremity muscles; normal sensation throughout bilateral lower extremities with intact deep tendon reflexes (DTRs) 2+ symmetrically. The provider listed diagnoses to include chronic neck pain/ cervical spondylosis and instability C3-7/ rule out stenosis; Chronic lower back and bilateral lower extremity pain/ spondylosis and instability at L2-3, L4-5, L5-S1/ rule out stenosis; no signs/symptoms of cord compression or cauda equina syndrome; chronic pain management. It was noted "As she is neurologically intact, there is absolutely no indication for surgical intervention." "As she is intact fully, I will continue with her physical therapy, acupuncture, and anti-inflammatory medicines." Reports showed unchanged symptom complaints and exam findings. The request(s) for Terocin patch, QTY: 60, Dispensed Terocin patch, QTY: 30 and MRI of Lumbar Spine were non-certified citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patch, QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: This 61 year-old patient sustained an injury on 11/28/12 while employed by [redacted]. Request(s) under consideration include Terocin patch, QTY: 60, Dispensed Terocin patch, QTY: 30, and MRI of Lumbar Spine. Diagnoses include cervical spondylosis; lumbosacral strain/sprain; CTS; and shoulder strain/sprain. The patient continues to treat for chronic ongoing symptoms. Medications list Prilosec, Ibuprofen, and Flexeril. There is a UDS report dated 6/2/14 with inconsistent findings of non-prescribed Hydrocodone and Hydromorphone positive. [redacted] provider report of 6/12/14 noted patient with chronic ongoing neck, shoulder, and low back pain from being rear-ended. Conservative care has included medications, physical therapy, acupuncture, and modified activities/rest. Exam showed intact findings of cervical spine; lumbar findings of normal gait; no paraspinal spasm or pain on palpation; minimal limited flexion range; positive SLR; negative Faber; 5/5 motor strength throughout lower extremity muscles; normal sensation throughout bilateral lower extremities with intact DTRs 2+ symmetrically. The provider listed diagnoses to include chronic neck pain/ cervical spondylosis and instability C3-7/ rule out stenosis; Chronic lower back and bilateral lower extremity pain/ spondylosis and instability at L2-3, L4-5, L5-S1/ rule out stenosis; no signs/symptoms of cord compression or cauda equina syndrome; chronic pain management. It was noted "As she is neurologically intact, there is absolutely no indication for surgical intervention." "As she is intact fully, I will continue with her physical therapy, acupuncture, and anti-inflammatory medicines." Reports showed unchanged symptom complaints and exam findings. The request(s) for Terocin patch, QTY: 60, Dispensed Terocin patch, QTY: 30, and MRI of Lumbar Spine were non-certified. The provider has not submitted any new information to support for topical compound analgesic Terocin which was non-certified. Per manufacturer, Terocin is Methyl Salicylate 25%, Menthol 10%, Capsaicin 0.025%, Lidocaine 2.5%, Aloe, Borage Oil, Boswelia Serrat, and other inactive ingredients. Per MTUS, medications should be trialed one at a time and is against starting multiples simultaneously. In addition, Boswelia Serrate and topical Lidocaine are specifically "not recommended" per MTUS. Per FDA, topical Lidocaine as an active ingredient in Terocin is not indicated and places unacceptable risk of seizures, irregular heartbeats and death on patients. The provider has not submitted specific indication to support this medication outside of the guidelines and directives to allow for certification of this topical compounded Terocin. Additionally, there is no demonstrated functional improvement or pain relief from treatment already rendered for this chronic injury nor is there any report of acute flare-up, new red-flag conditions, or intolerance to oral medications as the patient continues to be prescribed multiple oral meds. The Terocin patch, QTY: 60 are not medically necessary and appropriate.

Dispensed Terocin patch, QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: This 61 year-old patient sustained an injury on 11/28/12 while employed by [redacted]. Request(s) under consideration include Terocin patch, QTY: 60, Dispensed Terocin patch, QTY: 30, and MRI of Lumbar Spine. Diagnoses include cervical spondylosis; lumbosacral strain/sprain; CTS; and shoulder strain/sprain. The patient continues to treat for chronic ongoing symptoms. Medications list Prilosec, Ibuprofen, and Flexeril. There is a UDS report dated 6/2/14 with inconsistent findings of non-prescribed Hydrocodone and Hydromorphone positive. [redacted] provider report of 6/12/14 noted patient with chronic ongoing neck, shoulder, and low back pain from being rear-ended. Conservative care has included medications, physical therapy, acupuncture, and modified activities/rest. Exam showed intact findings of cervical spine; lumbar findings of normal gait; no paraspinal spasm or pain on palpation; minimal limited flexion range; positive SLR; negative Faber; 5/5 motor strength throughout lower extremity muscles; normal sensation throughout bilateral lower extremities with intact DTRs 2+ symmetrically. The provider listed diagnoses to include chronic neck pain/ cervical spondylosis and instability C3-7/ rule out stenosis; Chronic lower back and bilateral lower extremity pain/ spondylosis and instability at L2-3, L4-5, L5-S1/ rule out stenosis; no signs/symptoms of cord compression or cauda equina syndrome; chronic pain management. It was noted "As she is neurologically intact, there is absolutely no indication for surgical intervention." "As she is intact fully, I will continue with her physical therapy, acupuncture, and anti-inflammatory medicines." Reports showed unchanged symptom complaints and exam findings. The request(s) for Terocin patch, QTY: 60, Dispensed Terocin patch, QTY: 30 and MRI of Lumbar Spine were non-certified. The provider has not submitted any new information to support for topical compound analgesic Terocin which was non-certified. Per manufacturer, Terocin is Methyl Salicylate 25%, Menthol 10%, Capsaicin 0.025%, Lidocaine 2.5%, Aloe, Borage Oil, Boswelia Serrat, and other inactive ingredients. Per MTUS, medications should be trialed one at a time and is against starting multiples simultaneously. In addition, Boswelia Serrata and topical Lidocaine are specifically "not recommended" per MTUS. Per FDA, topical Lidocaine as an active ingredient in Terocin is not indicated and places unacceptable risk of seizures, irregular heartbeats and death on patients. The provider has not submitted specific indication to support this medication outside of the guidelines and directives to allow for certification of this topical compounded Terocin. Additional, there is no demonstrated functional improvement or pain relief from treatment already rendered for this chronic injury nor is there documented intolerance to oral medication as the patient is currently taking several oral prescriptions. The Dispensed Terocin patch, QTY: 30 are not medically necessary and appropriate.

MRI of lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: This 61 year-old patient sustained an injury on 11/28/12 while employed by [redacted]. Request(s) under consideration include Terocin patch, QTY: 60, Dispensed Terocin patch, QTY: 30, and MRI of Lumbar Spine. Diagnoses include cervical spondylosis; lumbosacral strain/sprain; CTS; and shoulder strain/sprain. The patient continues to treat for chronic ongoing symptoms. Medications list Prilosec, Ibuprofen, and Flexeril. There is a UDS report dated 6/2/14 with inconsistent findings of non-prescribed Hydrocodone and Hydromorphone positive. [redacted] provider report of 6/12/14 noted patient with chronic ongoing neck, shoulder, and low back pain from being rear-ended. Conservative care has included medications, physical therapy, acupuncture, and modified activities/rest. Exam showed intact findings of cervical spine; lumbar findings of normal gait; no paraspinal spasm or pain on palpation; minimal limited flexion range; positive SLR; negative Faber; 5/5 motor strength throughout lower extremity muscles; normal sensation throughout bilateral lower extremities with intact DTRs 2+ symmetrically. The provider listed diagnoses to include chronic neck pain/ cervical spondylosis and instability C3-7/ rule out stenosis; Chronic lower back and bilateral lower extremity pain/ spondylosis and instability at L2-3, L4-5, L5-S1/ rule out stenosis; no signs/symptoms of cord compression or cauda equina syndrome; chronic pain management. It was noted "As she is neurologically intact, there is absolutely no indication for surgical intervention." "As she is intact fully, I will continue with her physical therapy, acupuncture, and anti-inflammatory medicines." Reports showed unchanged symptom complaints and exam findings. The request(s) for Terocin patch, QTY: 60, Dispensed Terocin patch, QTY: 30 and MRI of Lumbar Spine were non-certified. Review indicated patient had recent MRI of lumbar spine dated 3/28/14 showing mild multilevel disc bulges and degenerative facet changes without significant central canal, neural foraminal stenosis or nerve impingement. Per ACOEM Treatment Guidelines for the Lower Back Disorders, under Special Studies and Diagnostic and Treatment Considerations, states Criteria for ordering imaging studies include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for repeating the MRI of the Lumbar spine nor document any specific clinical findings to support this imaging study as the patient has intact neurological exam without deficits throughout bilateral lower extremities nor is there any acute flare-up or new injury to indicate for repeat study. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The MRI of Lumbar Spine is not medically necessary and appropriate.