

<b>Case Number:</b>	CM14-0205355		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	03/07/2010
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Internal Medicine, 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 (IW) is a 66-year-old man with a date of injury of March 7, 2010. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are lumbago with bilateral radiculopathy and neuropathic pain; cervical and thoracic disease; sacroiliac joint and facet joint arthropathy; myofascial syndrome involving the whole spine; subscapular neuropathy; and reactive sleep disturbance. Pursuant to a progress note dated October 16, 2014, the IW complains of pain in the cervical, thoracic and lumbar spine. He also has myofascial pain and neuropathic pain in multiple areas. Objectively, the IW is alert and oriented X 4. The IW has sciatic notch tenderness bilaterally. There is positive straight leg raise bilaterally with a positive Lasegue's. Current medications include Oxycodone 30mg, Neurontin 800mg, Monarch pain cream, and Terocin 4% Lidocaine patch. The IW has been taking Oxycodone since at least August 21, 2014 according to a progress note with the same date. The treating physician reports that he will also add Hydromorphone, Oxymorphone, or Dilaudid in the form of 8mg TID to the medication regimen. The IW continues to have diffuse sensory deficit in the lower extremities bilaterally throughout L3, L4, L5 and S1. There is focal tenderness over the facets bilaterally with a positive facet provocation. There is significant motor weakness in the upper extremities bilaterally, in grip as well as flexion, extension, internal, and external rotation. The injured worker's functional status has remained stable. His pain scores remain in the low, moderate range. According to the utilization review (UR), a urine drug screen (UDS) dated February 19, 2014 was positive for Cocaine. There was no further discussion or documentation in the medical record regarding the positive findings in the UDS. The current request is for Terocin 4% Lidocaine patches #30, and Oxycodone HCL 30mg #300.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin 4% Lidocaine patch # 30:** Upheld

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

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

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Terocin 4% lidocaine patch #30 is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy or safety. They 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. Other than Lidoderm, no other commercially approved topical formulation of lidocaine with a cream, lotion or gel is indicated for neuropathic pain. In this case, the injured worker's working diagnoses are lumbar disc disease with radiculopathy and neuropathic pain; cervical and thoracic disc disease; sacroiliac joint and facet joint arthropathy; myofascial syndrome; supra-scapular neuropathy; and reactive sleep disturbance. Lidocaine is not recommended in any commercially approved topical formulation other than Lidoderm. Any compounded product that contains at least one drug (lidocaine) that is not recommended is not recommended. Terocin 4% lidocaine patch is not recommended. Consequently, lidocaine in the Terocin 4% formulation Lidocaine patch is not recommended and therefore, Terocin 4% lidocaine patch #30 is not medically necessary.

**Oxycodone HCL 30 mg #300:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Topical Analgesics.

**Decision rationale:** Pursuant to the Chronic Pain Management Treatment Guidelines and the Official Disability Guidelines, Oxycodone 30 mg #300 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication you side effects. A detailed pain assessment should accompany ongoing opiate use. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improve quality of life. The lowest possible dose should be prescribed to improve pain function. In this case, the injured worker's working diagnoses are lumbar disc disease with radiculopathy and neuropathic pain; cervical and thoracic disc disease; sacroiliac joint and facet joint arthropathy; myofascial syndrome; supra-scapular neuropathy; and reactive sleep disturbance. The documentation indicates oxycodone was

prescribed as far back as August 21, 2014. At that time the injured worker had partial relief with oxycodone. The injured worker also had relief with the Terocin patch. The treating physician added Dilaudid 8 mg po t.i.d. There is no clinical rationale to support the addition of Dilaudid, another opiate. The documentation does not contain any evidence of objective functional improvement. Additionally, there was a urine drug screen positive for cocaine in the UR. Consequently, absent the appropriate clinical documentation with objective functional improvement, clinical indication/rationale for the addition of Dilaudid, Oxycodone 30 mg #300 is not medically necessary.