MAXIMUS Federal Services

Case Number:	CM15-0049135		
Date Assigned:	03/23/2015	Date of Injury:	02/02/2008
Decision Date:	05/01/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/16/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 45-year-old male, who sustained an industrial injury on 2/2/08. He reported back and knee injuries. The injured worker was diagnosed as having postoperative laminectomy with instrumentation and fusion at L5-S1, status postoperative transforaminal interbody fusion for L3 to S1 with pedicle screw instrumentation and left knee injury. Treatment to date has included laminectomy, discectomy with partial facetectomies, partial lateral menisectomy and chondroplasty, spinal cord stimulator. (MRI) magnetic resonance imaging of the lumbar spine and left knee have been performed. Currently, the injured worker complains of ongoing low back pain and bilateral radicular pain with numbness of the lower extremities. On physical exam, tenderness was noted to palpation over left paravertebral spine and muscles with spasms and trigger pints noted and range of motion was limited in all planes. The treatment plan consisted of request for (MRI) magnetic resonance imaging of left knee and continuation of current medications of naproxen, omeprazole, Terocin patch, Terocin cream and Flurbiprofen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesic Page(s): 112.

Decision rationale: The patient presents with ongoing low back pain and bilateral radicular pain with numbness of the lower extremities. The request is for TEROCIN CREAM. The RFA provided is dated.02/02/15. Patient's diagnosis included postoperative laminectomy with instrumentation and fusion at L5-S1, status postoperative transforaminal interbody fusion for L3 to S1 with pedicle screw instrumentation and left knee injury. Patient is permanent and stationary. Terocin cream is considered a topical analgesic and contains methyl salicylate, capsaicin, lidocaine, menthol. MTUS Guidelines page 112 on topical lidocaine states, "recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants or an EAD such as gabapentin or Lyrica)." Topical lidocaine in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially-approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. MTUS Guidelines do not allow any other formulation of lidocaine other than in patch form. Terocin lotion consists of lidocaine, which is not indicated as a topical formulation by MTUS Guidelines. Therefore, the requested Terocin cream IS NOT medically necessary.

Terocin Patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical lidocaine topical analgesic Page(s): 56-57, 112. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm.

Decision rationale: The patient presents with ongoing low back pain and bilateral radicular pain with numbness of the lower extremities. The request is for TEROCIN PATCHES. The RFA provided is dated.02/02/15. Patient's diagnosis included postoperative laminectomy with instrumentation and fusion at L5-S1, status postoperative transforaminal interbody fusion for L3 to S1 with pedicle screw instrumentation and left knee injury. Patient is permanent and stationary. MTUS guidelines page 57 states, "topical lidocaine 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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, chapter 'Pain (Chronic)' and topic 'Lidoderm (Lidocaine patch)', it specifies that Terocin patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. Treater does not document the area of treatment nor how the patches will be used, with what efficacy. The

patient presents with pain consistent with a neuropathic etiology and confirmed via the EMG study conducted on 06/17/14; the patient was confirmed for the diagnosis of chronic severe left L4-S1 radiculopathy; however, the patient does not present with localized peripheral neuropathic pain which is a criteria required for Lidocaine patch use. These patches are not indicated for low back pain or axial chronic pain. Therefore, the request IS NOT medically necessary.

Flurbiprofen Cream: Upheld

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

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

Decision rationale: The patient presents with ongoing low back pain and bilateral radicular pain with numbness of the lower extremities. The request is for TEROCIN PATCHES. The RFA provided is dated 02/02/15. Patient's diagnosis included postoperative laminectomy with instrumentation and fusion at L5-S1, status postoperative transforaminal interbody fusion for L3 to S1 with pedicle screw instrumentation and left knee injury. Patient is permanent and stationary. The MTUS guidelines, page 111, do not support the use of topical NSAIDs such as Flurbiprofen for axial, spinal pain, but supports its use for peripheral joint arthritis and tendinitis. In this case, none of the progress reports document the use or purpose of the Flurbiprofen cream. There is no diagnosis of peripheral joint arthritis and tendinitis for which topical NASIDs are indicated. Hence, the request IS NOT medically necessary.