MAXIMUS Federal Services

Case Number:	CM13-0063363		
Date Assigned:	12/30/2013	Date of Injury:	04/29/2009
Decision Date:	09/24/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	12/10/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has noaffiliation with the employer, employee, providers or the claims administrator. The expertreviewer is Board Certified in Family Medicine and is licensed to practice in California. He/shehas been in active clinical practice for more than five years and is currently working at least 24hours a week in active practice. The expert reviewer was selected based on his/her clinicalexperience, education, background, and expertise in the same or similar specialties that evaluateand/or treat the medical condition and disputed items/services. He/she is familiar with governinglaws and regulations, including the strength of evidence hierarchy that applies to IndependentMedical 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 53-year old maintenance worker reported cumulative trauma to multiple body parts on 2/1/12. Diagnoses included headaches. brachial neuritis, lumbar disc disease, lumbar spondylosis, lumbar spinal stenosis, lumbar radiculopathy, bilateral medical epicondylitis of the elbows, lateral knee sprain, insomnia, anxiety, depression and sexual dysfunction. Multiple other diagnoses have since been added including acid reflux, constipation, diabetes, blurred vision and a sleep disorder. Treatment has included multiple oral and topical medications, physical therapy, chiropractic manipulation and acupuncture. Knee surgery was recommended but apparently not performed. There are no 2013 notes in the available records from the patient's primary treater, who is a pain specialist. The following information was primarily gleaned from the references to 2013 visits in the 11/12/13 UR report. The primary treater saw the patient on 9/3/13. At that visit the patient was given prescriptions for Norco 10, Tramadol ER, and Xanax. Acupuncture was prescribed, and a request was made for extracorporeal shock wave lithotripsy. Two boxes containing Terocin patches were dispensed, 20 patches in all. At a 10/15/13 recheck, the patient's complaints included frequent severe headaches, constant severe neck and low back pain, and moderate bilateral elbow and knee pain. A note was made that topical medications and acupuncture "increase sleep, decrease oral medications, increase chores". Notable findings on exam included diffuse tenderness, decreased neck and back range of motion, and decreased sensation "at L4-S1". The patient's work status was totally disabled. (He has not worked since 3/1/12.) The request for 2 boxes of Terocin patches was reviewed in UR on 11/12/13, and non-certified. A request for IMR was made on 12/9/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF TEROCIN PAIN PATCHES, 2 BOXES: Upheld

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

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

Decision rationale: The first MTUS guideline cited above states that medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. According to the second guideline cited above, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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. Lidocaine is indicated for localized neuropathic pain if there is evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Only FDA-approved products are indicated, and no other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Topical Lidocaine is not indicated for non-neuropathic pain. Since Terocin patches contain menthol, Lidocaine, methyl salicylate and capsaicin, 4 medications were started at once when they were dispensed. They were apparently started at the same time as Norco, Tramadol, Xanax and acupuncture. No clear assessment of the patient's functional level was made or goals were set. In this setting, it would be virtually impossible to assess the effect of any of the medications in the Terocin patch. No attempt was made to classify the patient's pain, so it is unclear how much of it might be neuropathic, if any. There is no documentation of a trial of an SNRI or an AED. Lidoderm patches, which are the only FDA-approved form of topical Lidocaine, would not have been indicated in this case. Non-FDA forms of topical Lidocaine such as Terocin are never indicated. Based on the evidence-based references above and the clinical findings in this case, Terocin patches are not indicated. Terocin patches are not medically necessary because they are not FDA-approved, because an appropriate evaluation of the patient's status and goals of treatment were not documented, and because they do not meet criteria for beginning a new medication.