

<b>Case Number:</b>	CM14-0185726		
<b>Date Assigned:</b>	11/13/2014	<b>Date of Injury:</b>	05/03/2011
<b>Decision Date:</b>	12/19/2014	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2014

### 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, has a subspecialty in Interventional Spine 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 patient is a 26 years old male with an injury date on 05/03/2011. Based on the 09/26/2014 progress report provided by the treating physician, the patient complains of "left thoracic pain and scapular pain began to increase last week rated as an 8/10. He describes the pain as severe." The patient also complains of numbness in the right hand and right knee pain that buckles. Physical exam reveals tender to touch over the left scapula and left thoracic spine. Thoracic range of motion is decreased with pain. The patient's diagnoses were not included in the file for review. There were no other significant findings noted on this report. The utilization review denied the request on 10/21/2014. The requesting provider provided treatment reports from 04/18/2014 to 09/26/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin times 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines.

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

**Decision rationale:** According to the 09/26/2014 report, this patient presents with "left thoracic pain and scapular pain began to increase last week rated as an 8/10." The current request is for Terocin times 2. Terocin patches are a dermal patch with 4% lidocaine, and 4% menthol. The treater states "both medications have proved effective in treating C. F.'s condition and has been well tolerated by the patient with no adverse effects noted." The MTUS guidelines state that Lidocaine patches may be recommended for neuropathic pain that is peripheral and localized when trials of antidepressants and anti-convulsion have failed. ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case the treating physician has not documented that a trial of antidepressants and anti-convulsion have failed, the location of trial of the lidoderm patches is not stated and there is no clear documentation of neuropathic pain. The request is not medically necessary.

**Thoracic spine trigger point injections:** 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), Low Back-Lumbar & Thoracic

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain section, trigger point injections Page(s): 22.

**Decision rationale:** According to the 09/26/2014 report, this patient presents with "left thoracic pain and scapular pain began to increase last week rated as an 8/10." The current request is for Thoracic spine trigger point injections. Regarding trigger points, MTUS recommends injections if examination findings show tenderness with taut band and referred pain. In this case, the examination does not show trigger points with taut band and referred pain pattern as required by the MTUS guidelines. The request is not medically necessary.

**Menthoderm times 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines.

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

**Decision rationale:** According to the 09/26/2014 report, this patient presents with "left thoracic pain and scapular pain began to increase last week rated as an 8/10." The current request is for Mentoderm times 2. Mentoderm gel contains Methyl salicylate and Menthol. Regarding topical non-steroidal anti-inflammatory drugs (NSAIDs), MTUS states, "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." The MTUS Guidelines state that topical NSAIDs are indicated for peripheral joint arthritis and tendinitis. In

this case, the treating physician has not clearly documented that the right knee complaint is arthritic in nature and MTUS does not support topical NSAIDs for spinal conditions. The request is not medically necessary.