

Case Number:	CM13-0065001		
Date Assigned:	02/11/2014	Date of Injury:	05/17/2001
Decision Date:	10/07/2015	UR Denial Date:	11/15/2013
Priority:	Standard	Application Received:	12/12/2013

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: New York

Certification(s)/Specialty: Internal Medicine

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 female who was injured on 5-17-2001. The request is for Terocin lotion #2 bottles. The UR dated 11-15-2013 indicated, non-certification of Terocin lotion #2 bottles. The medical diagnoses have included: acute right hip pain, greater trochanteric bursitis, low back pain, myoligamentous injury of the lumbar spine, right leg pain, and insomnia. On 6-3-2013, she reported pain to the right lateral hip with radiation into the right leg and thigh, and continued low back pain. She indicated she was having difficulty with sleep. Physical findings revealed she was tense, distressed, had guarded movements of the right hip, full range of motion to the right hip, tenderness in the low back, an antalgic gait that favored the right hip. The treatment plan included: education, physical therapy, home exercises, Terocin cream, Vicodin, x-rays of the right hip and lumbar spine. Diagnostic testing was not indicated within the documentation. The prior treatments and results were not indicated within the documentation. The documentation does not indicate failure of oral medications. The documentation does not indicate when Terocin cream was originally prescribed of the efficacy of the topical agent.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin Lotion #2 Bottles: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating Terocin. This medication contains Methyl Salicylate, Capsaicin, Menthol, and Lidocaine. MTUS states that Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.