

<b>Case Number:</b>	CM15-0024612		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	11/08/1989
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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, Pain Management

### 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 60 year old female with an industrial injury dated 11/06/1989. She presents on 01/14/2015 with complaints of continued low back pain. She rates the pain as 10/10. Exam of the lumbar spine revealed decreased range of motion with pain. There was tenderness to palpation on the left lumbar paraspinal musculature, left lumbar 3-4 radiculopathy. There was a positive Lasegue's and straight leg raise on the left. MRI of lumbar spine dated 10/05/2012 and MRI of left wrist dated 01/10/2015 are in the submitted records. Prior treatments include lumbar spine epidural injection and medications. Diagnoses were: Lumbar discogenic disease- Lumbar radiculopathy-Chronic low back pain-Multi-level lumbar spondylosis- Multi-level spinal stenosis secondary to multi-factorial. On 01/26/2015 utilization review issued the following decisions:- The request for Temazepam 30 mg # 30 was modified to Temazepam 30 mg # 24. MTUS was cited.-The request for Terocin Lotion 180 grams was denied. MTUS was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin Lotion 180 Grams QTY:1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic creams or patches Page(s): 111-113.

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

**Decision rationale:** Regarding the request for Terocin, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "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." Topical lidocaine is "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)." Additionally, it is supported only as a dermal patch. Capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested Terocin is not medically necessary.

**Temazepam 30mg Tablets QTY:30.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** Regarding the request for Temazepam, Chronic Pain Medical Treatment Guidelines state the benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks." "Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant." Within the documentation available for review, there is no documentation identifying any objective functional improvement as a result of the use of the medication and no rationale provided for long-term use of the medication despite the CA MTUS recommendation against long-term use. Benzodiazepines should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Temazepam is not medically necessary.