

Case Number:	CM13-0021173		
Date Assigned:	11/08/2013	Date of Injury:	08/30/1998
Decision Date:	06/16/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/06/2013

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. The expert reviewer is Board Certified in Internal Medicine and Cardiology; has a subspecialty in Cardiovascular Disease and is licensed to practice in Texas. 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:

This is a male patient who reported an injury on August 30, 1999. The patient is currently diagnosed with lumbar discogenic pain, lumbar radiculopathy, right shoulder status post rotator cuff surgery with residual and right total knee arthroplasty with residual. [REDACTED] recently saw the patient on August 20, 2013 with complaints of low back, right shoulder, and right knee pain. The patient reported chronic 5-6/10 pain. Physical examination revealed positive straight leg raising on the right, positive Lasgue's testing, 5/5 motor strength, hyporeflexic patella and Achilles bilaterally, restricted range of motion, laxity of the right knee, 2+ positive Lachman anterior drawer testing, tenderness to palpation along the medial and lateral joint line, restricted range of motion, mild effusion, poor quadriceps strength, 0 to 90 degrees forward abduction of the right shoulder, positive impingement sign, and tenderness to palpation at the subacromial space. Treatment recommendations included physical therapy twice per week for 6 weeks, continuation of current medications, and a return office visit in 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, 2 tablets by mouth four times a day: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to present with high levels of pain over multiple areas of the body. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in functional level, or improved quality of life. Therefore, the request is not medically appropriate.

NEURONTIN 300MG, 2 TABLETS BY MOUTH THREE TIMES A DAY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-18.

Decision rationale: The California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. A good response to the use of anti-epilepsy drugs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction in pain. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report high levels of pain to multiple areas of the body. Documentation of significant changes in the patient's physical examination indicative of a functional improvement was not provided. Satisfactory response to treatment has not been indicated. Therefore, the request is not medically appropriate.

TEROCIN CREAM: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. According to the clinical notes submitted, there is no evidence of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Terocin contains methyl salicylate, capsaicin, menthol, and lidocaine hydrochloride. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments, and is indicated for osteoarthritis, fibromyalgia, and chronic nonspecific back pain. Topical lidocaine in the formulation of a dermal patch has been designated by the FDA for neuropathic pain. No

other commercially-approved topical formulation of lidocaine (creams, lotions, or gels) is indicated for neuropathic pain. The California MTSU Guidelines further state any compounded product that contains at least one drug or drug class that is not recommended, is not recommended as a whole. Therefore, the request is not medically appropriate.