

<b>Case Number:</b>	CM13-0034566		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	07/02/2012
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 52-year-old male who reported an injury on 07/02/2012. The mechanism of injury was not stated. Current diagnoses include lumbar radiculitis, lumbago, lumbar sprain/strain, and left hip bursitis/tendinitis. The injured worker was evaluated on 09/16/2013. The injured worker reported constant lower back pain with radiation to the left lower extremity and left hip pain. Physical examination revealed limited lumbar range of motion, positive straight leg raising on the left, hypertonicity, limited left hip range of motion, and decreased sensation in the L5-S1 dermatome on the left. Treatment recommendations included continuation of Terocin 240 ml and compounded creams.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TEROCIN 240ML:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There

was no frequency listed in the current request. Therefore, the request is not medically appropriate. Additionally, the injured worker was issued a prescription for the requested topical analgesic in 08/2013. There was no evidence of objective functional improvement following the ongoing use of this medication. As such, the request for Terocin 240 ml is not medically certified.

**FLURBI (NAP) CREAM LA 180GMS:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There was no frequency listed in the current request. Therefore, the request is not medically appropriate. Additionally, the injured worker was issued a prescription for the requested topical analgesic in 08/2013. There was no evidence of objective functional improvement following the ongoing use of this medication. As such, the request for Flurbi (NAP) Cream LA 180 gms is not medically necessary.

**GABACYCLOTRAM 180GRAMS:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There was no frequency listed in the current request. Therefore, the request is not medically appropriate. Additionally, the injured worker was issued a prescription for the requested topical analgesic in 08/2013. There was no evidence of objective functional improvement following the ongoing use of this medication. As such, the request for Gabacyclotram 180 grams is not medically necessary.

**TEROCIN PAIN PATCH BOX (10 PATCHES) #3:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is no frequency listed in the current request. There is also no mention of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. As such, the request for Terocin Pain Patch Box (10 Patches) is not medically necessary.