

<b>Case Number:</b>	CM14-0007363		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	09/20/2010
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	01/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 Internal Medicine and is licensed to practice in North Carolina, Colorado, California and Kentucky. 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 36 year old male who was reported to have sustained work related injuries on 09/20/10. On this date he was reported to be carrying a tray full of food from the kitchen to the dining room of a restaurant when he tripped and fell on a wet floor falling backwards. He sustained injuries to his right knee and shoulder, neck, and low back. He was status post right knee surgery on 09/26/11. He underwent partial medial meniscectomy, chondroplasty of the medial femoral condyle, and synovectomy. Post-operatively the injured worker had continued complaints of knee pain with weight bearing. MRI of the lumbar spine dated 01/06/11 noted presence of degenerative disc disease with facet arthropathy. There was mild canal stenosis at L4-5. There was a left lateral protrusion contacting the exiting left nerve root at L5-S1. The claimant was maintained on oral medications including Cymbalta 60mg, Ibuprofen 600mg, Gabapentin 300mg, and Terocin cream. The utilization review determination dated 01/07/14 non-certified request for Terocin cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE TEROGIN LOTION 2.5-25-0.025.10 %:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compounded medications

**Decision rationale:** The request for one Terocin lotion 2.5-25-0.025.10% is not supported as medically necessary. The California Medical Treatment Utilization Schedule, Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.