

<b>Case Number:</b>	CM14-0065470		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	06/21/2006
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	04/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in 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 71-year-old male who reported an injury on 06/21/2006 due to a trip and fall. On 03/04/2014 the injured worker presented with persistent deltoid pain. Upon examination of the bilateral shoulders the range of motion was 90 degrees of abduction that caused deltoid pain, and internal rotation of 30 degrees causing anterior shoulder pain. There is a positive impingement maneuver. There was tenderness along the right subacromial space and left biceps. There was left elbow pain with wrist extension and a positive Speed's maneuver. Current medications include Terocin and Ultram. The provider recommended Terocin pain cream for the right shoulder, to reduce pain. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro terocin pain cream right shoulder:** 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): 111.

**Decision rationale:** The request for retro Terocin pain cream is not medically necessary. Terocin cream is comprised of methyl salicylate, capsaicin, menthol, and Lidocaine. California MTUS Guidelines state that topical compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Additionally, any compounded product that contain at least 1 drug that is not recommended, is not recommended. The guidelines state that capsaicin is recommended only as an option if injured workers who have not responded or are intolerant to other treatments. The guidelines state that the Lidoderm patch is the only topical form of Lidocaine approved. The included medical documents do not indicate that the injured worker has not responded to or are intolerant to other treatments. The guidelines do not recommend topical Lidocaine in any other form other than Lidoderm. Included medical documents lack evidence of a failed trial of antidepressants or anticonvulsants. The request does not indicate the frequency, dose, or the site at which the Terocin, and cream was intended for. As such, the request is not medically necessary.