

<b>Case Number:</b>	CM14-0095093		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	04/07/2006
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	06/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

There were 252 pages provided for this review. The claimant injured his low back lifting a heavy air-conditioner. He treated at [REDACTED] on and off for six weeks. On returning to work, his restrictions were that he was to work two hours less and be allowed to sit. There was a utilization review from May 8, 2014. The claimant was injured back in the year 2006. The diagnosis was a lumbar sprain, myalgia, myositis and lumbosacral neuritis. The clinical note from May 1, 2014 was handwritten and illegible. There continued to be some pain in the back with bilateral leg numbness and some weakness of the legs. The claimant is currently not working. Physical exam showed positive straight leg raising with decreased sensation in both feet and decreased strength. There was decreased range of motion in all planes and bilateral paraspinal muscle spasm. A Terocin patch would be tried for numbness in both lower extremities. The patient did not tolerate Neurontin. A TENS unit was also prescribed as was Omeprazole and non-steroidal anti-inflammatory medicines as needed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin Patch #10:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Topical Analgesics Page.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111 OF 127. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Physician Desk Reference, under Terocin

**Decision rationale:** Per the PDR, Terocin is a topical agent that contains: Methyl Salicylate 25% Capsaicin 0.025% Menthol 10% Lidocaine 2.50% The MTUS Chronic Pain section notes: Salicylate topicals Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded. Topical Analgesics Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin: Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. These agents however are all over the counter; the need for a prescription combination is not validated. Moreover, the records say the patch would be used for 'numbness' when this medicine does nothing for numbness. The request is appropriately non-certified under MTUS criteria.