

<b>Case Number:</b>	CM15-0000140		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	10/09/2003
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	12/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 injured worker is a 58 year old female, who sustained an industrial injury on October 9, 2003. The mechanism of injury was a slip and fall. The diagnoses have included a lumbar four-lumbar five disc protrusion, cervical pain and low back pain. Treatment to date has included medication management, ice treatment, physical therapy treatments, an MRI of the lumbar spine on March of 2012 and an H-wave device. The injured worker was noted to have failed physical therapy and the H-Wave device. She had a history of a cervical fusion. Current documentation dated November 24, 2014 notes that the injured worker reported low back pain with radiation to the left hip and intermittent pain into the left lateral leg down to the knee. Physical examination of the lumbar spine revealed a positive straight leg raise on the left and on the right it caused low back pain. Her gait was noted to be slowed and wide. The injured worker had increased left radicular symptoms and weakness in left lumbar five myotomes as well as distribution of pain in the lumbar five dermatome. On December 10, 2014 Utilization Review non-certified a request for Terocin Patches, times one month. The MTUS, Topical Analgesic Guidelines were cited. On December 31, 2014, the injured worker submitted an application for IMR for review of a one month supply of Terocin Patches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin patches for one month:** Upheld

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

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

**Decision rationale:** The injured worker sustained a work related injury on October 9, 2003. The medical records provided indicate the diagnosis of lumbar four-lumbar five disc protrusion, cervical pain and low back pain. Treatment to date has included medication management, ice treatment, physical therapy treatments, and an H-wave device. The medical records provided for review do not indicate a medical necessity for Terocin patches for one month. Terocin is a topical analgesic containing Methyl Salicylate 25%; Capsaicin 0.025%; Menthol 10%, and Lidocaine 2.50%. The MTUS does not recommend any compounded product that contains at least one drug (or drug class) that is not recommended. Therefore, since menthol is not recommended, the requested treatment is not medically necessary and appropriate.