

<b>Case Number:</b>	CM15-0197991		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	02/24/2005
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2015

### 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: California, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 65 -year-old male who sustained an industrial injury on 2-24-2005. Diagnoses have included lumbar disc injury with facet arthralgia, left more than right sciatica, xerostomia, nonindustrial right knee injury, and right lateral epicondylitis. On 7-29-2015, the injured worker complained of continued severe low back pain radiating down his left leg to the foot rated as 4 out of 10 on the VAS pain scale. In the 9-15-2015 note, he stated that the pain can reach 10 out of 10 with some activities. Objective examination revealed muscle spasm in multiple neck, thoracic and lumbar areas, tenderness in lumbar spinous processes and facet joints and left sacroiliac joints, with noted decreased range of motion in the neck and lower back areas. Documented treatment includes TENs unit, use of braces, chiropractic treatments, physical therapy, home exercise, prolotherapy and epidural steroid injections, trigger point injections, swimming, a detoxification program followed by a functional restoration program, and medication. The 7-29-2015 note states the injured worker has tried multiple medication including Methadone, doxepin, meclizine, Lidoderm patch, theramacare, heat wraps, Kadian, Hydrocodone, Celebrex, trazadone, Diclofenac cream, bupropion, Lexapro, Opana, and Vicoden. The injured worker is noted to have symptoms related to possible sleep apnea, and the physician verbalizes concerns regarding use of Methadone with that potential diagnosis. A sleep study has not been performed as of this note. The treating physician's plan of care includes 2 bottles of Terocin lotion, and 3 boxes of Terocin patches, which were both denied on 9-23-2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin lotion #2 bottles: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Johar, Pramod, et al. "A comparison of topical menthol to ice on pain, evoked tetanic and voluntary force during delayed onset muscle soreness." International journal of sports physical therapy 7.3 (2012): 314. Menthol does not provide significant improvements in functional status for patients with knee arthritis.

**Decision rationale:** Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 "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. 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." In this case, terocin is composed of methyl salicylate, capsaicin, menthol and lidocaine hydrochloride. According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 56 and 57, regarding Lidocaine, may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case, the exam note from 7/29/15 demonstrates there is no evidence of failure of first line medications such as gabapentin or Lyrica. Therefore, the request is not medically necessary and non-certified.

**Terocin patches #3 bottles: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 "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. 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." In this case, terocin is composed of methyl salicylate, capsaicin, menthol and lidocaine hydrochloride. According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 56 and 57,

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