

<b>Case Number:</b>	CM15-0084012		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	02/18/2014
<b>Decision Date:</b>	06/08/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 51-year-old female who sustained an industrial injury on 2/18/14. The injured worker was diagnosed as having lumbar spine strain and bilateral knee sprain/strain. Currently, the injured worker reported complaints of lower back pain with radiation to the lower extremities, knee pain and right shoulder pain. Previous treatments included activity modification, medication management and physical therapy. Previous diagnostic studies included a magnetic resonance imaging of the right shoulder revealing a completely retracted rotator cuff tear, type 2 acromion and degenerative changes at the acromioclavicular joint. Bilateral knee magnetic resonance imaging revealed posterior to mid horn tears of the medial meniscus. The plan of care was for medication prescriptions and a follow up appointment at a later date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CycloTram cream with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 22;111-113.

**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): 111-113 of 127.

**Decision rationale:** Regarding the request for CycloTram cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants are not supported by the CA MTUS for topical use. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested CycloTram cream is not medically necessary.