

<b>Case Number:</b>	CM14-0147105		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	05/07/2001
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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 Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 51-year-old male who reported an injury on 05/07/2001. The mechanism of injury was not submitted for clinical review. The diagnosis included left shoulder pain, and cervical disc disorder. The previous treatments included medication. Within the clinical note dated 07/28/2014, it was reported the injured worker complained of pain. He rated his pain 2/10 in severity with medication, and 9/10 in severity without medication. Upon the physical examination, the provider noted the injured worker had restricted movement of the left shoulder with a positive Hawkins test. The provider indicated the injured worker had limited motor testing and limited by pain. Tenderness was noted in the cervical spine, paracervical muscles, and trapezius muscles. The request submitted is for Bengay greaseless cream. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(1) Prescription of Bengay greaseless cream 15-10%: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

**Decision rationale:** The request for a prescription of Bengay greaseless cream 15-10% is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the request submitted failed to provide the treatment site. Therefore, the request is not medically necessary.