

<b>Case Number:</b>	CM14-0098882		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	05/17/2011
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/27/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 39-year-old female was reportedly injured on May 17, 2011. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated May 13, 2014, indicates that there are ongoing complaints of neck pain, low back pain, left upper extremity pain, and insomnia. The injured employee also had complaints of allodynia, dysesthesia, and hyperesthesia of the left upper extremity. Current medications include ibuprofen, Terocin patches, hydromorphone, and topical analgesics. The physical examination demonstrated motor weakness of the left upper extremity. There was decreased range of motion of the left shoulder and abduction and adduction. There was tenderness over the biceps tendon and over the left sided brachial plexus. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes oral and topical medications. A request had been made for [REDACTED] Pain cream, gabapentin/lidocaine, and Terocin/lidocaine and was not certified in the pre-authorization process on June 6, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**[REDACTED] Pain Cream Containing Ketoprofen, #1 Tube: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112 of 127.

**Decision rationale:** The California MTUS Guidelines support topical NSAIDs for the short-term treatment of osteoarthritis and tendinitis for individuals unable to tolerate oral non-steroidal anti-inflammatories. The guidelines support 4-12 weeks of topical treatment for joints that are amendable to topical treatments; however, there is little evidence to support treatment of osteoarthritis of the spine, hips or shoulders. When noting the injured employee's concurrent prescription of ibuprofen and complaints of cervical spine pain and shoulder pain, this request for [REDACTED] Pain cream containing ketoprofen is not medically necessary.

**Gabapentin/Lidocaine, #1 Tube:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112 of 127..

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents including gabapentin. Per the MTUS, when one component of a product is not necessary the entire product is not medically necessary. Considering this, the request for gabapentin/lidocaine is not medically necessary.

**Terocin 4% Lidocaine Patch:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic, Patch.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112 of 127.

**Decision rationale:** Terocin is a topical analgesic containing Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.50%. According to the California Chronic Pain Medical Treatment Guidelines the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents. Per the MTUS, when one component of a product is not necessary the entire product is not medically necessary. Considering this, the request for Terocin/lidocaine patch is not medically necessary.